IMPLEMENTATION OF THE MEDICARE DRUG BENEFIT

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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IMPLEMENTATION OF THE MEDICARE DRUG BENEFIT

WEDNESDAY, JUNE 14, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:42 a.m., in room 1100, Longworth House Office Building, the Hon. William M. Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
June 07, 2006
FC–21

CONTACT: (202) 225–1721

Thomas Announces Hearing on Implementation of the Medicare Drug Benefit

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on implementation of the Medicare prescription drug benefit, beneficiary enrollment and lessons learned now that the initial enrollment deadline of May 15 has passed. **The hearing will take place on Wednesday, June 14, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Administration officials, among others. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On December 8, 2003, the President signed into law the Medicare Modernization Act (MMA, P.L. 108–173), which created a new Part D benefit in the Medicare program to provide coverage for outpatient prescription drugs. The benefit became available January 1, 2006, and the initial enrollment period ended May 15. Estimates by the Department of Health and Human Services (HHS) indicate an estimated 38 million seniors, or about 90 percent, have either signed up for the benefit or may have other coverage that is at least as generous as Medicare's standard benefit.

The Centers for Medicare and Medicaid Services (CMS) estimates that on May 15 alone, 640,000 calls were handled through the 1–800 MEDICARE line, and 143,875 individual enrollments were logged on the Medicare.gov web site. This is the largest single day online sign up total since enrollment began on November 15, 2005. Over the weekend leading up to May 15, online enrollment activity reached 57,494 individual enrollments—four to five times greater than any other weekend in 2006.

For Medicare beneficiaries who did not sign up by the deadline, the next opportunity to enroll is November 15, 2006 for coverage starting in January, 2007. For low income subsidy eligible individuals, CMS has created a special enrollment period through the end of the year. For all seniors there is a late enrollment premium penalty equal to one percent of the average national base premium amount per month. Some have suggested waving this penalty and/or extending open enrollment through the end of the year to all beneficiaries.

Prior to the law, few outpatient drugs were covered by Medicare and many seniors who did not have prescription drug coverage through another source either individually assumed this financial burden or went without prescription drugs. Since January 2006, almost a quarter of a billion prescriptions have been filled under the new Medicare prescription drug program, and drug cost savings are significant for many.

In announcing the hearing, Chairman Bill Thomas stated, "America's seniors looked at the plans available to them, made choices about what best fit their individual needs and signed up by the millions. I'm pleased to see the robust enrollment in the program. Choice of plans proves competition is working. As a result, prices, premiums and drug costs are down. For months, naysayers have been calling for

a deadline extension—the same people who spent the past 12 months discouraging seniors from signing up in the first place. The deadline worked to encourage action. Now that we're past the deadline we will examine the situation to find out just exactly what happened, where the successes were, and why. Most importantly, we must examine the situation to make sure that we make future decisions about the program based upon facts and not on suppositions."

FOCUS OF THE HEARING:

The hearing will focus on implementation of the new Part D benefit, enrollment in the new program and lessons learned from the initial enrollment deadline.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Wednesday, June 28, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. Good morning. Today the Committee turns its focus to the implementation of the Medicare prescription drug program. As of May 15th, the initial enrollment period for non-low-income beneficiaries to sign up for the new benefit has concluded. As we will hear from our witnesses, millions of seniors signed up for the new program. It was with the help of numerous volunteer groups, obviously, Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), a lot of State activities. After all, it was a movement to a new Federal program—a number of others.

We will hear, I believe, and see evidence as many as 90 percent of Medicare beneficiaries now have some sort of prescription drug program. I do want to say at the outset of this hearing that this success has come in spite of some pretty bitter partisan politics. America's seniors have been able to see through the enormous negativity from many individuals in trying to convince anyone who would listen that this benefit was a farce.

It was also that same negativity that the media reported on for most of the 6-month enrollment period. Only near the end did we begin to see articles catching on to the real substance of the program's benefits and to the fact that millions of seniors are now better off with Medicare's prescription drug coverage.

A number of Members in both the House and the Senate have introduced proposals to either waive the late enrollment penalty on seniors who have not yet signed up or extend the enrollment deadline through the end of the year.

There may be some discussion about another voluntary portion of Medicare part B and the number of people who have not signed up for this as well as voluntary program and the number of people who are paying late fees based upon their choices. However, these proposals to modify the structure were written before we really knew what the landscape looked like following the initial enrollment period.

Today's hearing, I think, should function under a kind of an oversight model. Today's hearing is designed to begin to get the facts, understand them, and then examine whether or not based upon the facts we should act.

It is the Chair's intention during this hearing and future hearings, if necessary, to find out just exactly what happened during the past 6 months. What were the successes? To what extent can we learn how to deal with the ongoing enrollment aspects of Medicare Part D in making sure that seniors get connected quickly with the kind of information that would be helpful to them? Where are the areas that still need to be addressed? Who are the individuals that, despite all of those excellent outreach programs, were either missed and through no fault of their own are not in the program?

As this Committee examines potential changes to the program, I would urge my colleagues to base our future decisions on facts, not on suppositions or political pressure. Finally, I do want to underscore the fact that this is this Committee's second hearing on this issue. It comes at a time when people are talking about what Congress is doing, and there have been some comments. I think oversight activities are absolutely critical. I do believe it is appropriate to have oversight hearings when there has been an ample

opportunity to examine what it is that we want to oversee and present evidence that will allow us to have a reasoned discussion to look at choices for the future.

The Committee on Ways and Means plays such a major role in so many important government programs such as this one that we want to ensure that taxpayers dollars are spent wisely, but that the purpose of oversight is to make wise decisions legislatively in the near future.

Chairman THOMAS. Now, I recognize the gentleman from New York, Mr. Rangel, for any opening comments he may wish to make.

Mr. RANGEL. Thank you, Mr. Chairman, and I always thank you for the nonpartisan atmosphere which you manage to create at these hearings so that we can move forward in dealing with the Secretary. Mr. Secretary, I hope that anyone who disagrees with you that you do not accept as a partisan Democrat. Some of us are citizens, we have constituents, they have problems, and we do expect to talk about them. You can help us a great deal if you could share with us what you intend to do about the problems we get. We don't have people rushing to our office saying, this is a great program, thank you so much. We have people who have fallen in the cracks, those who expect to be penalized, and I know that you have given some thought as to how you are going to handle those type of problems. You can help us a great deal if you could—if you can share with us your ideas to make us better Representatives, whether we are Republican or Democrat.

Mr. Chairman, I would like to yield the balance of my time to Congressman Stark, who is the Ranking Member of the Subcommittee on Health.

Mr. STARK. Thank you.

Chairman THOMAS. He is recognized.

Mr. STARK. Thank you, Mr. Rangel. I think that we have to all agree that we can do better. This program can work better for beneficiaries, providers and indeed for taxpayers. I would challenge and will challenge the numbers that the Administration brings forth. I think they have massaged them to put a shiny face on often sad problems.

I would challenge the Chair's suggestion that the Democrats did not promote this program. In my own case, in October of 2005, we sent out a rather substantial, I think 100,000, color brochures to all of our—every post office box and holder in our district urging seniors and relatives and friends of seniors to sign up, suggesting where they could go for help, and we did not—we warned them that they should check to make sure they wouldn't lose private insurance or government insurance, which I think the Secretary also did. To suggest that we in any way tried to dissuade people from signing up I think counters the fact.

I would be happy to challenge any Members of the Committee on both sides of the aisle to see who sent out more literature in favor of the plan and how early it was done. I think that is—I don't think you can find one Democrat who suggested to any constituents that they not sign up. To suggest otherwise, I think, is not correct.

On the other hand, we have been critical of the program which we felt was written by the industry and for the industry, without any chance for Democrats to participate, and I think we get to a

bottom line today that we should leave the enrollment open because it has been confusing, and it is not confusing because of the seniors, it is confusing because the program was written in a confusing manner, and we should waive the penalty. There is no reason, and we will ask the Secretary later to find the cost. There is precious little cost to anybody, and to not allow open enrollment until the end of the year, and to waive the penalty to the end of the year to me is mean-spirited, and it is us, the Federal Government, who caused these problems.

We should be willing—I understand that it would cost $2 billion out of $1 trillion to let enrollment open and waive the penalty until next year. To me that is just adding insult to injury to many, and particularly to the poorest seniors who suffer the most. We would like to improve the program and move ahead. I don't think anybody on our side would suggest that we repeal the program, but we certainly think that we can do better.

Thank you, Mr. Chairman.

Mr. DOGGETT. Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Any other Member who wishes to make an opening statement can do so in the usual manner in terms of a written statement for the record.

Mr. DOGGETT. Mr. Chairman.

Chairman THOMAS. Gentleman from Texas.

Mr. DOGGETT. As you recognize these two very important witnesses, can you advise us whether either has any time constraint or other constraint that will prevent all Members of the Committee from inquiring fully of them about the important issues we consider today?

Chairman THOMAS. I thank the gentleman, and that is an important question. My understanding is that the Secretary will be with us with an opening statement and an opportunity to respond. He does have an appointment at noon, and I told him that in all probability that doesn't need to be canceled. It is an important appointment because Dr. McClellan will be with us, who probably, as the Administrator of CMS, has on-the-ground, day-to-day knowledge, which is probably what this Committee is most interested in.

It is not to say that Secretary Leavitt isn't important in building the car, but when we are going to ask about overhauling the fuel injection and the transmission, Dr. McClellan is the one who is Mr. Goodwrench. I think he will be available probably as long as he wants to and as long as the Committee wants him to. With that, it is my pleasure to welcome Secretary of the Department of Health and Human Services, the Honorable Michael O. Leavitt, along with Dr. Mark McClellan. Gentlemen, you have written testimony. It will be submitted as part of the record, but you may address us in the time available in any way you see fit. Mr. Secretary, welcome.

STATEMENT OF THE HONORABLE MICHAEL O. LEAVITT, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Thank you, Mr. Chairman, Members of the Committee.

When the President signed this into law in December of 2003 (P.L. 108–173), it brought the biggest change in Medicare in some 40 years. Introduction of the new benefit created an unprecedented

opportunity and, I might, say also a breathtaking challenge. The opportunity, as the President put it, was for over 42 million older Americans to have, quote, better choices and more control over their care so they could receive the modern medicine and modern—the American medical care that they deserve.

The challenge was to reach these millions of seniors and people with disabilities, to educate them about the benefits of the prescription drug program and to help them select the best plan. The challenge has been met, and today well over 38 million Americans, more than 90 percent of the people with Medicare, have the promise that they can have prescription drugs. Well over 3 million Medicare Part D prescriptions are being filled every day, and the cost of monthly premiums is down nearly 40 percent than the original estimates. Thanks to Part D, seniors are saving an average of $1,100 a year.

The numbers are impressive, but the truth is it is really the people. It was about families coming together with countless millions of Americans helping their parents, their grandparents and other loved ones to decide which of the plans best meets their needs. This is about neighborhoods that came together in church basements and school gyms and libraries and senior centers where countless Americans selflessly donated their time to help seniors and disabled folks in their communities.

May 15, 2006, was the conclusion of the initial enrollment period, and in the final 2 weeks alone, with the help of loving friends and family and caring volunteers, over 2 million seniors signed up for Part D prescription benefit programs. Our Medicare RX bus traveled more than 600,000 miles bringing Part D messages directly into communities large and small all over America.

The events I attended and the people I met convinced me that Part D represents much more than just the implementation of the new Federal program. The grass-roots outreach effort was what I like to call a network of caring, a network of caring that came together around Part D and took on a life all its own in a way that is truly remarkable, in my judgment, and a singular moment in American history. The seniors needed help. They needed help in making choices. Yes, they had a choice to make. It would have been easier just to have a single one-size-fits-all drug plan. In fact, the government did exactly that. We created the standard plan intended to meet the needs of some Medicare beneficiaries. A one-size-fits-all plan does not fit all, especially when dealing with health care needs of an aging population.

The reality is that less than 10 percent of the enrollees are enrolled in the standard government-designed plan. Once people work through their choices, the vast majority selected plans that were better tailored for their individual health needs. While it is rewarding to reflect on what has been accomplished, we must now, of course, look forward. Our work did not end on May the 15, 2006. We have to continue to reach out to those who have not yet enrolled, especially low-income seniors who can still enroll without penalty. We will continue to work on improvements to Part D. We will continue to review all the things that we have learned during that important first year.

For the longer term, we are working together to incorporate Part D prescription drug coverage into a larger strategy of prevention. Of the remaining 4.4 million Americans with Medicare who didn't enroll in Part D during the initial period, over 3 million are expected to meet low-income criteria and, thus, can sign up now without incurring any penalty for comprehensive coverage with little or no premium. In addition, Medicare is using its authority to enable low-income Medicare beneficiaries to continue to ensure that they have access to multiple premium drug plan options next year. When Part D was enacted, experts estimated that the average monthly premiums were around $37. That came down considerably. As you know, it was under $24 in May.

I just say in the moment that remains, we are all getting better at this. During the last 5 months, we have seen consumers become better educated and better informed. We have seen the drug plans learn to operate in a more efficient way. We have seen the pharmacies learn to use the system. We have become better at HHS in our role. America has changed the health care scene forever, and what I saw as I traveled America was remarkable, a country that reached out, helped its seniors and will provide them with a healthier and safer America. Thank you.

[The prepared statement of Secretary Leavitt follows:]

Statement of Michael O. Leavitt,
Secretary, Department of Health and Human Services

Testimony Before the House Committee on Ways and Means

Wednesday, June 14, 2006

Good morning, Chairman Thomas, Congressman Rangel, and members of the Committee. I appreciate the opportunity to testify before your committee today to discuss the success of the Medicare Prescription Drug Benefit. I submit for the record the Secretary's Progress Report IV on the Medicare Prescription Drug Benefit.

This report, which is the subject of my testimony today, is the most recent of four reports submitted to Congress to chart the progress and the success of the Medicare Part D benefit. This particular report illustrates the latest enrollment numbers, average savings for seniors, the scope of outreach efforts, lessons learned, as well as a look at the future.

Again, I thank the Chairman and the Committee for the opportunity to testify on this important issue and am happy to answer questions.

MedicareRx
Prescription Drug Coverage

Secretary's Progress Report IV on the Medicare Prescription Drug Benefit

Prepared by Mike Leavitt,
Secretary of Health and Human Services

June 14, 2006

An American Moment

When President Bush signed the law creating the Medicare Part D Prescription Drug Benefit on December 8, 2003, he brought about the biggest change in Medicare in forty years. Introduction of the new benefit created an unprecedented opportunity and a breathtaking challenge.

The opportunity, as the President put it, was for over 42 million older Americans to have "better choices and more control over their health care, so they can receive the modern medical care they deserve."

President George W. Bush, Secretary Mike Leavitt, and the Medicare Rx bus. *HHS photo by Chris Smith.*

The challenge was to reach out to those millions of seniors and people with a disability, to educate them about the benefits of the prescription program, and to help them select the best plan.

The challenge has been met, and today, for over 38 million Americans – more than 90 percent of people with Medicare – the promise is being fulfilled, day in and day out, prescription by prescription. In fact, well over 3 million Part D prescriptions are being filled each day, and the cost of monthly plan premiums are nearly 40 percent lower than original estimates. Thanks to Part D, seniors are saving an average of $1,100 a year.

The numbers are impressive, but this is really about people. It was about families coming together, with countless millions of Americans helping their parents, grandparents or other loved ones decide which plan best meets their specific needs.

This was about neighborhoods coming together, in church basements and school gyms, libraries and senior centers, where countless Americans selflessly donated their time to help seniors and disabled folks in their communities. May 15th was the conclusion of the initial enrollment period, and in the final two weeks alone, with the help of loving friends and family and caring volunteers, over two million seniors signed up for their Part D prescription benefits.

Our Medicare Rx bus traveled more than 600,000 miles bringing the Part D message directly to communities large and small across America. The events I attended and the people I met convinced me that Part D represents much more than the implementation of a new federal program. The grassroots outreach effort– what I like to call a national "network of caring" – that came together around Part D took on a life all its own in what became a truly remarkable undertaking – a singularly American moment.

Marie is a 71-year old native of Birmingham, Alabama, a 10-year breast cancer survivor who spent $7,351 on prescriptions last year. When she enrolled in a Medicare prescription drug plan and received extra help from Social Security, her costs dropped to only $1,351 a year.

The seniors needed help because they had choices to make. Yes, the choice would have been easier had there been a single one-size-fits-all drug plan, and in fact the government did create a standard plan intended to meet the needs of some Medicare beneficiaries.

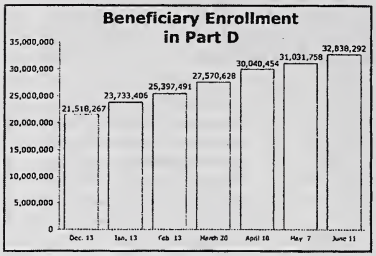
But one size does not fit all, especially when dealing with the health care needs of an aging population. The reality is that less than 10 percent of the enrollees are enrolled in the standard government-designed plan. Once people worked through their choices, the vast majority selected plans that were better tailored to their individual health needs.

While it is rewarding to reflect on what has been accomplished, we must now look forward. Our work did not end on May 15th. We must continue to reach out to those who are not yet enrolled, especially low-income seniors, who may still enroll without incurring a penalty. We will continue to work on improvements to Part D as our review of all that we have learned during this crucial first year continues. All of these changes and improvements will result in a Medicare program that keeps getting better.

For the longer-term, we are working to incorporate Part D prescription drug coverage into a larger strategy of prevention to improve the health of all Medicare beneficiaries. We have begun to close the prescription drug coverage gap. Now we must help seniors utilize benefits to close the prevention gap – keeping seniors healthy and identifying health issues at the earliest stage possible.

Joann, of Greenville, South Carolina, is the caregiver for her 89-year old mother, who was paying about $4,200 a year for medications. Working with a counselor, they discovered that Joan's mom qualified for extra help, and they found a plan that saves her more than $1,600 a year.

Enrollment



Enrollment grew by approximately one million sign-ups per month leading up to the May 15th deadline and then surged as over two million seniors selected plan coverage during the final two weeks. In total, over 38.2 million Americans – 90 percent of all Medicare beneficiaries – now have prescription drug coverage.

The steady growth reflects two things: first, the positive buzz that developed as seniors began to experience the significant savings offered by Part D prescription coverage, and second, the momentum that our ambitious grassroots outreach program built as the Part D message was carried across the country.

The fact that the end-of-enrollment surge was handled without problem is testament to the foresight and dedication of the Centers for Medicare & Medicaid Services, led by Administrator Mark McClellan.

More than 6,000 customer service representatives were added to the 1-800-MEDICARE staff in anticipation of this last-minute surge and the number of call centers was expanded from eight to 23. More than 648,000 calls were taken on that last day of enrollment, over 200,000 calls more than on any previous day in the history of 1-800-MEDICARE. Despite this deluge, the average wait time for calls on the last day of enrollment was only a little over 12 minutes, and wait times in the final two weeks averaged under five minutes.

Millions of people not only researched their plan on the Web; they enrolled on the Web. Over the weekend leading up to May 15th, more than 57,000 seniors enrolled online – four to five times greater than any previous weekend. That number was eclipsed on May 15th when an extraordinary 143,875 individual enrollments occurred online. In all, some 3.6 million seniors enrolled via www.medicare.gov.

Helping the Most Needy

Of the remaining 4.4 million Americans with Medicare who did not enroll in Part D during the initial enrollment period, over 3 million are expected to meet low-income criteria and can sign-up now without incurring a penalty for comprehensive coverage with little or no premium. We are working through both local and national partnerships to reach these beneficiaries and help them in applying for the low-income subsidy and enrolling in a Part D plan. In addition, Medicare is using its authority to enable low-income Medicare beneficiaries to continue to have access to multiple zero-premium drug plan options next year.

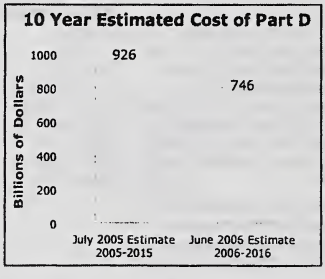
> **"Complaints at pharmacies have dropped precipitously, and callers who once found it impossible to get through to congested help lines now typically wait only a few minutes when trying to reach either Medicare or most individual health plans."**
>
> — "The Drug Benefit: A Report Card," New York Times editorial, Monday, June 5, 2006

Choice and Competition Work!

When Part D was enacted, experts estimated that the average monthly premium would be around $37. Our analysis of actual enrollment finds that the average 2006 Part D premium is less than $24, nearly 40 percent below the original estimate. This represents strong competition plus informed beneficiary choices. The overall 2006 cost to the taxpayer has dropped about 20 percent from the July 2005 estimate, and estimates for the net total cost to Medicare for the ten-year period from 2006 to 2015 has been cut by $180 billion. State phase-down contributions over the same period are now projected to be $39 billion less.

Meeting Challenges

There are challenges to initiating a program of this scale, and we had ours. From the beginning, we have been committed to anticipating operational issues whenever possible and solving unforeseen problems. The power of the Internet was harnessed to make the fullest array of information available 24/7. Call centers were beefed up. We pushed plans to ease the burden on pharmacists.



Perhaps the greatest challenge was establishing a seamless exchange of data between the many systems and parties involved. Despite problems for some beneficiaries at the start, we succeeded in making data exchanges across the system far more consistent, accurate and reliable, so that new beneficiaries are swiftly connected to their drug coverage. One June 1, after the May enrollment surge, millions of beneficiaries started their new drug coverage smoothly.

Carrie, an enrollment volunteer from Idaho Falls, Idaho helped a family reduce their expenses by over 80%, amounting to more than $8,000 dollars in annual savings. "This family is exactly who Part D was designed to help," Carrie said, "I felt it was a good day for me when I could help them."

Thank You

The grassroots outreach program that we launched to carry the Part D message across America took on compelling momentum in the final days of the enrollment period. This has been a truly remarkable undertaking that brought out the best in the tens of thousands of Americans across the country who came together during the initial enrollment period to form this network of caring:

- 20,000 local and national partner organizations such as the AARP, the NAACP, State Health Insurance Assistance Programs and various seniors organizations;
- 40,000 volunteers who selflessly staffed more than 50,000 local enrollment events across the country;
- 30,000 pharmacists who joined physicians, nurses and other health care professionals on the front lines of the outreach effort;
- Those who staffed the Medicare Rx bus, which traveled more than 600,000 miles to bring the Part D message directly to communities large and small across America;
- And, most importantly – the millions of family members who helped a loved one decide which plan best met their specific needs.

Melba is an 83-year old cashier in Phoenix, Arizona. She does not currently take any medications but wanted to enroll in a plan so she would be covered in the future. She found a plan that only costs $8.00 a year.

To everyone who took the time to help a fellow American enroll in Part D, I say thank you for a job well-done.

Newspaper Headlines

Washington Post – 5/17/06
"New Medicare Drug Plan Is Called a Success. Officials Cite Significant Rise In Coverage"

Providence Business News – 5/15/06
"Medicare Part D Sign-ups Surpass All Expectations"

Elmira Star-Gazette – 5/14/06
"Part D Program Has Helped Improve Medicare"

Dallas Morning News – 5/12/06
"Medicare Prescription Drug Plan: 'It Turned Out To Be So Easy,' Says Couple"

Fort Wayne Journal-Gazette – 5/8/06
"Plan D Wins Converts"

La Prensa Newspaper (Orlando, FL) – 5/5/06
"Ahorre Con La Cobertuna De Medicare Para Recetas Médicas" (Save With Medicare Prescription Drug Coverage)

NY Times – 4/27/06
"Medicare Rule Guarantees Continuity of Drugs"

Grand Forks Herald – 4/26/06
"Saving Serious Money: Seniors Sign Up For Medicare Part D At Workshop"

Lincoln Journal-Star – 4/12/06
"Medicare Enrollment Event Brings Good News For Many"

Washington Post – 4/12/06
"Most Seniors Enrolled Say Drug Benefit Saves Money"

The Repository of Canton, OH – 2/22/06
"Seniors Needing Prescriptions Singing Praises Of Medicare, Not 'Oh, Canada!'"

Des Moines Register – 2/5/06
"Iowa Poll: Iowans Back Prescription Drug Benefit"

New York Times – 2/3/06
"Federal Costs Dropping Under New Medicare Drug Plan, Administration Reports"

Looking to the Future: Building on the Initial Success of Medicare Part D

Our work did not end on May 15th.

Our first priority is to continue to reach out to Medicare beneficiaries with limited means, who have not yet enrolled, who can enroll without penalty and without waiting for the next enrollment period to open in November.

Obviously, everyone has learned from the Part D startup. We have already begun to apply those lessons as we issue guidance on how organizations should bid and contract for the succeeding year. We've clarified how organizations can market their plans, to ease comparisons for beneficiaries. We expect formularies – the listing of drugs covered – to include a full range of treatment options. Medicare will continue to approve all formularies, and we have issued guidance on smoothing the transition when beneficiaries switch plans. And we announced that beneficiaries may not be left without coverage for the drugs they use should a plan drop a particular drug from its formulary.

Because the prescription program was new, plans developed their coverage options without experience with what seniors preferred. The result was some duplication and overlap. We expect that as beneficiaries choices change, competition and our program oversight may drive plans to offer different coverage options only where there are meaningful differences between them. The net result will be to simplify the decision process for seniors while continuing to meet individual needs.

We have told plans to expect to demonstrate accountability. We plan to publish a variety of performance measures to assist beneficiaries in making enrollment decisions. These include such things as customer support, timely transmission of data, and the process and speed by which drug-denial appeals are handled.

In many respects, pharmacists are the untold heroes of the successful implementation of part D. Beginning at midnight on January 1, they were available for Medicare beneficiaries filling prescriptions; answering questions; enrolling beneficiaries in the plans that were right for them; and working through billing problems. We have worked with the plans, and will continue to do so, to ensure that the legitimate concerns that pharmacists have expressed related to timely payment and other billing issues are resolved promptly.

Finally, we intend to enlist the grassroots "network of caring" to bridge what we call the "prevention gap," the failure to take advantage of Medicare services designed to avoid illness. Too few seniors are having screening tests for cancer, diabetes, and cardiovascular disease. Too few get physical exams. Too few seek counseling and assistance to stop smoking. These simple services, all now covered under Medicare, have the potential to save thousands of lives while avoiding significant medical expenses in preventable medical conditions.

We can and must dramatically increase the number of seniors who take advantage of Medicare's preventive benefits.

Secretary Mike Leavitt and volunteers at a Florida help center.
HHS photo by Chris Smith.

MedicareRx
Prescription Drug Coverage

Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Thank you very much, Mr. Secretary. Dr. McClellan.

STATEMENT OF THE HONORABLE MARK B. MCCLELLAN, M.D., PH.D., ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MCCLELLAN. Madam Chairman, Congressman Rangel, distinguished Members, I want to thank you for the opportunity to provide you with an update on the implementation of the new prescription drug coverage here with Secretary Leavitt. We implemented a grass-roots Medicare strategy to provide more personalized support for our beneficiaries than ever before, including hard-to-reach populations, including those in rural areas, including the minority community. We created tools to provide personalized information to help beneficiaries find a plan that was a good fit and to help beneficiaries save even more on their drug costs through things like from switching to generic drugs. We linked these tools to an unprecedented grass-roots network of Medicare partners across the Nation.

We are going to use the same personalized tools and grass-roots support to help seniors use the drug benefit and other preventive benefits in Medicare effectively to improve their health and lower health care costs. Competition among the drug plans enables beneficiaries to choose plans that they prefer to any standard benefit designed by the government, as the Secretary mentioned. If you look at the slides we have available, I think you all have a copy of these on your seats, and we may be able to project them as well, as you can see on Chart 1, close to 90 percent of non-low-income beneficiaries selected plans other than the standard defined benefit, and all of the low-income beneficiaries are getting comprehensive coverage as well. That is—see we go to Chart 1.

Then, on Chart 2 you can see that most people enrolled in plans with no deductibles. Competition has also resulted in the cost of coverage being much lower than expected. Plans bid lower than expected because of strong competition, and then the beneficiaries used the support tools available to make informed choices, and they overwhelmingly chose low-cost plans. You can see this on Chart 3. About 76 percent of beneficiaries selected stand-alone prescription drug plans with the premium below the national average. Of those who enrolled in a Medicare Advantage plan on Chart 4, about half selected a plan with a zero premium for drug coverage.

[The prepared statement of Dr. McClellan follows:]

Statement of The Honorable Mark McClellan, M.D., Ph.D., Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

Chairman Thomas, Congressman Rangel, distinguished committee members, thank you for the opportunity to provide an update on the new Medicare prescription drug coverage, and especially the unprecedented outreach and education campaign the Centers for Medicare & Medicaid Services (CMS) undertook to maximize enrollment. I appreciate your interest in this topic, but more importantly I am very grateful for your personal assistance and that of many of your colleagues in driving the awareness of and enrollment in Part D. Members of Congress from both parties have been an important part of this massive grassroots education effort, for example, by supporting enrollment events sponsored by CMS and our thousands of part-

ners throughout the country. As a result of this undertaking an estimated 38.2 million beneficiaries—about 90 percent of people with Medicare—have drug coverage as of June 11, 2006. I am very hopeful that this partnership we have created can continue as we begin to drive greater awareness and use of the preventive benefits which the Congress included in the Medicare Modernization Act (MMA).

The broad participation of beneficiaries with relatively low drug costs, coupled with the overwhelming popularity of plans with low premiums and generally slower growth in drug costs, has lowered costs for Medicare. Beneficiaries selected plans that best met their needs, and often the plans they picked were not the standard benefit as designed in the MMA. Competition is working. Plans bid lower than expected, thereby helping to lower premiums to an average of less than $24 per month. The initial implementation of the new Medicare prescription drug benefit is complete. People with Medicare have access to the drugs they need most and are seeing significant savings as never before. In addition, people with Medicare have chosen plans that fit their coverage needs better than the "standard" benefit enacted by Congress, including coverage with no deductibles, flat copayments, and filling in the "coverage gap." As you know, change of this magnitude, to a program such as Medicare, in such a short time span is bound to encounter some difficulties. While considerable progress has been made in resolving start-up issues, CMS is very concerned about anyone who has experienced problems in obtaining their medicines. We have been and are continuing to take action to address these issues as they arise so that all beneficiaries enrolled in a Medicare prescription drug plan can obtain their medications without incident.

CMS also is preparing for next year and has taken numerous steps to improve the prescription drug program for Medicare beneficiaries. For example, CMS has worked with pharmacists to improve data systems and simplify business processes between pharmacies and the Medicare prescription drug plans, such as using standard denial notices with sufficient information to explain those denials. We have issued guidance in several key areas that stresses our commitment to plan sponsor oversight. For example, CMS issued guidance to outline CMS' expectations of plans bidding to sponsor a prescription drug plan for the upcoming contract year. Recently, based on feedback from both beneficiaries and the health care industry, CMS released draft guidelines for 2007 on how organizations and their representatives may market their Medicare prescription drug plans to beneficiaries. One of the key changes in those draft guidelines is that Medicare prescription drug plans will not be permitted to place co-branding names and/or logos of providers on their member identification cards. This change will help prevent beneficiary confusion.

CMS will continue its strong commitment to oversight by monitoring and tracking plan compliance and performance. CMS will thoroughly review, investigate and resolve any reports of non-compliance. CMS has collected first quarter data in a number of areas and will use that information to monitor and track plan compliance and performance.

CMS and Partners Conducted Extensive Outreach and Education for Beneficiaries

CMS is pleased that about 90 percent of people with Medicare are receiving prescription drug coverage. This is due in large part to our multi-pronged strategy for educating and enrolling people in the new drug benefit. We realized early on that as we developed our outreach efforts, we would not be able to rely solely on traditional communication tools.

Before implementation of the drug benefit, CMS provided most information directly to beneficiaries using traditional tools, including the *Medicare & You* handbook, and standard information through 1–800–MEDICARE, and www.medicare.gov. While these more traditional tools would still play a valuable role in our efforts, CMS saw the need to develop new, more personalized strategies in order to reach a wider audience and to target specific, hard-to-reach populations, including those in rural areas and minority communities. In addition to print, radio and television advertisements, CMS implemented a multi-pronged approach to raise awareness and assist beneficiaries and their caregivers in making decisions about prescription drug plans.

CMS designed its Plan Finder tool to give people with Medicare specific, personalized information. Upon entering the medications they take, beneficiaries received information on the exact premiums, co-payments and annual deductibles they would be subject to under any of the plans available in their area. They were also given a figure showing their total annual expenses under each of those plans. The Plan Finder tool also provided information on the precise savings available to them by switching to generic medications. They might also look at coverage and savings available through a Medicare Advantage plan. This information, uniquely tailored

to that beneficiary's inquiry, could then be used to make an informed, personal decision. To help get this valuable information in the hands of our beneficiaries, however, we needed to provide them with a high level of one-on-one help.

When developing the Plan Finder, CMS worked with a professional website development contractor and engaged in a number of rounds of consumer testing to obtain feedback on the usefulness and simplicity of the tool. To ensure the continued accuracy of the information available through Plan Finder, CMS conducts thorough and ongoing analysis of the plan pricing data, pharmacy network, and formulary information. If problems are found with a plan's data, CMS has the ability to suppress information until it is corrected and can be properly displayed. This tool has been extremely successful in providing people with Medicare, their caregivers, and CMS' partners with clear, accurate and timely information to help them learn about and enroll in drug plans. This tool was vital to our enrollment efforts. About 3.6 million people enrolled in a plan through the Plan Finder. This accounts for more than one-third of all individuals who voluntarily selected and enrolled in a plan.

CMS knew from the outset that it was essential to provide beneficiaries with more hands-on assistance than was available in our traditional educational materials, through outreach events and one-on-one training. These outreach efforts would have to include high-touch and high-tech elements, with high-tech resources like the personalized Plan Finder web-based tool for use by our partners and beneficiaries, as well as high-touch efforts involving one-on-one personal contacts using an intricate web of grassroots partners collaborating and leveraging each other for the maximum benefit of people with Medicare. We believe that one-on-one counseling is important for people with Medicare to make confident decisions about their Medicare prescription drug coverage. To develop this grassroots network, CMS reached out to organizations that have contact with people with Medicare on a daily basis. To reach beneficiaries "where they work, live, play, and pray," we sought to involve individuals and institutions such as employers, churches and synagogues, financial advisors and community centers. By expanding beyond our traditional partners such as beneficiary and caregiver groups and CMS' regional office structure, we ensured that people with Medicare could receive necessary education and enrollment assistance at the community level.

CMS began reaching out during 2004 to develop these partnerships, and now the network is incredibly diverse and committed. For several months, we held training sessions throughout the country to educate our partners about the benefit structure and available enrollment tools so they could help raise awareness with, educate and enroll beneficiaries. CMS provided special training for social service coordinators to help them counsel low-income seniors. CMS relied heavily on our partner organizations to work with beneficiaries on a one-on-one basis.

We recognized that to achieve the promise of the MMA we would need to reach all segments of the Medicare population, especially underserved populations and those with language and other cultural barriers. To target these hard-to-reach populations, including minority, low-income, limited English-speaking, homebound, and rural populations, CMS has a contract with the National Association of Area Agencies on Aging. Strategies included contracting with Aging Network community-based organizations and nine National Aging Organizations with local affiliates to conduct outreach to low-income populations. As a major part of this targeted outreach, we developed specialized campaigns for the African-American, Hispanic, American Indian, Asian-American and Pacific Islander communities, utilizing new partnerships, creating materials in other languages, and doing specialized paid media campaigns. Currently, the proportion of minority enrollments in Part D exceeds the proportion of minorities in the overall population, indicating that our focused outreach efforts have been very successful.

More than 40,000 volunteers in communities across the country worked during the enrollment period, counseling beneficiaries and sponsoring events to help people with Medicare. During the entire open enrollment period from November 15, 2005 through May 15, 2006 our grassroots partners sponsored more than 50,000 Medicare events and opportunities for people to receive personalized assistance. Several thousand of these events were held during the last weeks of the enrollment period. Thanks to our national and local partners Medicare now has a permanent grassroots program, which will continue its efforts to encourage full use of the prescription drug benefit and begin helping our beneficiaries take advantage of the important new preventive benefits made available under the MMA.

As always, customer service is a priority at CMS to ensure beneficiaries and our partners are given accurate, timely information. With implementation of a brand new part of Medicare, CMS understands that people with Medicare, their families, doctors, and pharmacists will have questions about the new Medicare drug benefit. CMS' 1–800 MEDICARE Call Center has customer service representatives (CSRs)

available to answer Medicare questions 24 hours a day, seven days a week with assistance in English, Spanish and other languages as well. CMS' helpline and www.medicare.gov have served as critical tools for beneficiaries, caregivers, and enrollment assistance centers to sign up for the benefit themselves or assist those they serve in doing so.

CMS' 1–800–MEDICARE line handled more than 27.5 million calls between November 15, 2005, and May 31, 2006. On May 15, 2006, the last day of the enrollment period, we handled nearly 650,000 calls. Call volume to 1–800–MEDICARE and use of the online enrollment center reached record levels on May 15 and was 58 percent higher than any other period of operation. The Agency takes great care in answering calls to 1–800–MEDICARE as promptly as possible and providing accurate, useful information to callers. Because of the great interest in the new drug benefit, call wait times have occasionally been longer than we would like. However, CMS has worked diligently to improve the wait times and I am pleased to say that current wait times are generally less than two minutes.

Lower Medicare Costs for Part D Estimated

CMS now projects lower than expected Part D expenditures. In 2006, beneficiary premiums are expected to average less than $24 a month—down from the $37 projected in last July's budget estimates—and the overall cost to taxpayers for 2006 has dropped about 20 percent since the July 2005 estimate, according to the CMS Office of the Actuary. The savings result from significantly slower than expected growth in drug costs generally in 2004 and 2005, which contributes to lower costs per beneficiary; the drug benefit complementing rather than replacing other sources of coverage, such as from employers; and, strong competition plus informed beneficiary choices leading to greater savings by beneficiaries choosing plans with greater price discounts, manufacturer rebates, and effective utilization-management savings by the drug plans.

Beneficiaries are tending to select low premium plans, and the vast majority has chosen plans other than the standard benefit. The availability of low-cost plans in every region contributed to the surge in PDP and MA–PD enrollment during the weeks leading up to the initial enrollment deadline. Substantial enrollment in Part D means that the risk pool for plans will not be unduly skewed toward those who have high demand for prescription medications. As a result, costs for the program will be moderated by those who pay their premiums, but do not need large amounts of medications. As with any insurance program, this spreading of the risk lowers costs for all involved and strengthens the ability of insurers to maintain a viable benefit in a competitive marketplace in the future.

For the 10-year period from 2006 to 2015, the net total cost of the drug benefit to Medicare is now estimated to be about $180 billion less—$746 billion compared to an estimated $926 billion last year.[1] In addition, the state phase-down contributions are now projected to be $39 billion (about 29 percent) less over the 10-year period.

It is important to note that the success of Part D does not eliminate the substantial issues with Medicare in general. Growth in Parts A and B exceeds previous estimates and Medicare is projected to have a long-term negative impact on the Federal Budget of $32 trillion over the next 75 years.

Medicare Beneficiaries with Drug Coverage Tops 38 Million

Of the estimated 42.6 million beneficiaries eligible for Medicare prescription drug coverage as of June 11, 2006, an estimated 38.2 million have drug coverage. This represents the estimated total number of beneficiaries with drug coverage through Medicare Part D (PDPs), Medicare Advantage plans with prescription drug coverage (MA–PDs), the Medicare retiree drug subsidy (RDS), Federal retiree coverage, or other sources of creditable coverage, such as the Veteran's Administration (VA). Some have argued that we should not be counting those who are not specifically covered under Part D. However, one of the intents of the MMA was to help beneficiaries who already had drug coverage continue it, so they would not need to transition to Part D so long as their coverage was as good as, or better than what Medicare had to offer—keeping Medicare costs down while preserving and supporting coverage, such as from former employers, that beneficiaries prefer. This saves money for the taxpayers, and it avoids disruptions for our beneficiaries who already have comparable coverage because they can simply continue with what they have.

The estimated total number of beneficiaries with drug coverage (38.2 million, including those with alternative creditable coverage) increased by more than 2 million

[1] The 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

between May 1 and the enrollment deadline due to the surge in enrollment in Medicare prescription drug plans and Medicare Advantage plans. Currently, about 32.8 million beneficiaries have drug coverage through PDPs, MA–PDs, employer/union retiree plans that qualify for the RDS, or Federal retiree coverage.

Total Medicare Beneficiaries with Drug Coverage

As of 6-11-2006

Description	June (millions)
Drug Coverage from Medicare or Former Employer	
Stand-Alone Prescription Drug Plan (PDP)	10.37
Medicare Advantage with Prescription Drugs (MA-PD)	6.04
Medicare-Medicaid (Automatically Enrolled)	6.07
Medicare Retiree Drug Subsidy (RDS)	6.90
FEHB Retiree Coverage	1.60
TRICARE Retiree Coverage	1.86
TOTAL	**32.84**
Additional Sources of Creditable Drug Coverage	
Veterans Affairs (VA) Coverage	2.01
Indian Health Service Coverage	0.11
Active Workers with Medicare Secondary Payer	2.57
Other Retiree Coverage, Not Enrolled in RDS	0.10
State Pharmaceutical Assistance Programs	0.59
TOTAL	**5.38**

More than 22.5 million beneficiaries are enrolled in Part D plans (PDPs and MA–PDs), including 10.4 million in stand-alone PDPs, about 6.0 million in MA–PDs, and 6.1 million full-benefit duals who were automatically enrolled.

Approximately 6.9 million beneficiaries are in employer/union retiree plans that are participating in the RDS program. This includes 1.5 million in employer/union group waiver plans that incorporate Medicare drug coverage, and another 400,000 who are in individual market Part D plans with stand alone employer/union wrap-around coverage.

There are an estimated 3.5 million beneficiaries with Federal retiree drug coverage through the Federal Employees Health Benefit program (FEHB) and TRICARE. This number has been revised from earlier estimates, as we have adjusted the number to account for the relatively small number of Federal retirees who have enrolled in a Part D plan.

More specifically, there are an estimated 1.6 million beneficiaries with FEHB retiree coverage. This figure is based on Office of Personnel Management (OPM) data on the actual number of annuitants with Medicare coverage and OPM's estimate of spouses with Medicare who are covered under a FEHB family policy. It excludes an estimated 32,000 beneficiaries who also are enrolled in Part D, based on OPM information on annuitants in FEHB plans.

In addition, there were an estimated 1.9 million beneficiaries with TRICARE retiree coverage, based on data provided by the Department of Defense (DoD). This number excludes about 133,000 people who were found to be enrolled in Part D plans based on a person-level data match.

Enrollment Also Accounts for Additional Sources of Prescription Drug Coverage

There were an estimated 5.4 million beneficiaries with creditable drug coverage (e.g., coverage that is at least as good as the Medicare Part D defined standard benefit) through an alternative source as of June 11, 2006. This number is based on the best available information about beneficiaries with drug coverage through the Department of Veterans Affairs, Indian Health Service (IHS), active worker em-

ployer group health plans, and retiree plans not participating in the retiree drug subsidy, and State Pharmaceutical Assistance Programs (SPAPs) who are not enrolled in Part D.

Creditable coverage through the above mentioned groups is estimated as follows:

- *Veterans Affairs (VA)*—There are an estimated 2.0 million beneficiaries with creditable drug coverage through the VA who have not signed up for Part D. About 1 million VA beneficiaries enrolled in a Part D plan, and about 400,00 are receiving drug coverage from an employer receiving the Part D subsidy. These numbers are based on a sample person-level match provided by the VA.
- *Indian Health Service (IHS) Coverage*—There are about 100,000 beneficiaries with creditable drug coverage through the IHS who are being served by I/T/U pharmacies in 28 States. These beneficiaries are not required to enroll in Part D, and have a disincentive for signing up because they might experience increased co-payments.
- *Active Workers with Medicare Secondary Payer*—There are nearly 2.6 million beneficiaries with creditable drug coverage through an employer group health plan.
- *Other Retiree Coverage*—An estimated 0.1 million retirees are continuing in retiree coverage who are not already included in the other retiree coverage categories. Some of these retiree plans may apply for the Medicare retiree subsidy in their next full plan year, while others may have only a limited number of eligible retirees so that the financial impact of the RDS is small.
- *State Pharmaceutical Assistance Programs*—An estimated 0.59 million beneficiaries are continuing to receive creditable coverage through State SPAPs. The estimate is based on information from four state SPAP programs that have creditable coverage and are not requiring enrollment in Part D plans in order to retain SPAP coverage (NJ, NY, PA, and WI) and a person level match of SPAP files with Part D enrollment files.

Currently, we estimate that about 11.6 million people have enrolled in Medicare Part D since the program began, including more than 1.2 million new enrollees in Medicare Advantage plans. In addition, other Medicare Advantage beneficiaries have more comprehensive and secure coverage, without benefit caps or limited formularies.

CMS estimates there are 13.2 million individuals whose income and assets are limited such that they would potentially qualify for the low-income subsidy. Current enrollment estimates for LIS eligible beneficiaries is detailed in the chart below.

LIS-Eligible Medicare Beneficiaries with Drug Coverage

As of 8-11-2006

Description	Total LIS-Eligible Beneficiaries (millions)
Total Beneficiaries Eligible for Low-Income Subsidy 1/	**13.2**
Less: Drug Coverage from Medicare or Former Employer 2/	**9.3**
SSA LIS Approved	1.8
Other Deemed Full/Partial Duals and SSI Recipients	7.5
Less: Additional Sources of Creditable Drug Coverage 3/	**0.5**
Veterans Affairs (VA) Coverage	0.3
Indian Health Service Coverage	0.1
SPAP Wraparound Coverage	0.1
Less: Anticipated Facilitated Enrollments 4/	**0.1**
TOTAL Remaining LIS-Eligible Beneficiaries	**3.3**

1/ CMS estimate based on analysis of updated SIPP and CPS survey data.
2/ CMS Management Information Integrated Repository (MIIR), June 11, 2006.
3/ CMS estimate of beneficiaries receiving coverage from other sources, June 2006.
4/ LIS-approved beneficiaries expected to be included in the next round of facilitated enrollments. CMS Management Information Integrated Repository (MIIR), June 11, 2006.

It is possible that some of the eligible beneficiaries who are not enrolled may have drug coverage through other sources that are not reflected in our enrollment estimates. For example, some may have opted to continue receiving drug coverage through Medigap plans (most of which are not creditable).

That means that for the first time in the history of the Medicare program about 90 percent of our beneficiaries have drug coverage either through Part D or another source that is just as good. This is great news since prior to the implementation of Part D, as although some beneficiaries had some type of drug coverage before Part D was implemented, not all of them had coverage as stable and comprehensive as what is now available through the Medicare prescription drug benefit. Often, these beneficiaries either had intermittent coverage, or had plans with higher premiums or less generous benefits.

Building On Larger-Than-Expected Savings from Strong Competition and Informed Beneficiary Choices

The new drug benefit enables Medicare to take steps to assure that beneficiaries get quality coverage at the lowest possible cost. Based on this year's experience with strong competition and informed beneficiary choices, Medicare will use its authority now in a way that will allow low-income beneficiaries to continue to have multiple zero premium drug plan options next year. Our intent is to determine how to make adjustments as necessary to moderate premium increases for all beneficiaries during the transition. We expect that this will result in premiums that will increase on average by about medical inflation, but that will depend on the actual plan bids, which we currently are starting to review.

To promote effective competition that builds on the savings achieved through beneficiaries' own choices this year, Medicare will implement a transitional approach to determining the federal contribution toward the premiums for the drug benefit for low-income Medicare beneficiaries in 2007. In particular, we will conduct a transition from the method of calculating the premium subsidy in 2006, before the unexpectedly high level of competitive savings in the drug benefit was observed, to the "weighted-average" method based on actual plan enrollments and costs. The transitional approach means low-income beneficiaries will have greater stability in

their zero-premium plan options, and it provided an additional incentive for plans to bid low to continue to serve low-income Medicare beneficiaries.

Medicare will also review the plan bids for 2007 to determine if transitional methods for determining the government's premium contribution for all beneficiaries are necessary to avoid any disincentives for beneficiaries to enroll in low-cost plans, which led to much lower costs than expected this year. We will evaluate the impact of the transitional approach for determining zero-premium choices for low-income beneficiaries, and any other transitional methods, to ensure that we are able to provide the most effective support for high-quality, low-cost drug coverage.

CMS Reaches Out to Low-Income Beneficiaries

We estimate that about 3.3 million of the beneficiaries who have yet to enroll are eligible for the low-income subsidy. CMS is continuing its outreach activities to low-income individuals. Anyone found eligible for the low-income subsidy will be able to enroll immediately rather than waiting for the next open enrollment period. In addition, beneficiaries eligible for the low-income subsidy who enroll during this special enrollment period (SEP) will not face a premium penalty for late enrollment. CMS is also working with Part D plans to identify and provide information about the low-income subsidy to beneficiaries who are enrolled in a plan and may qualify for the subsidy, but have not applied.

CMS coordinated with the U.S. Census bureau to identify counties with large numbers of potential LIS-eligibles and compared these data to enrollment figures to identify counties where a lower percentage of LIS-eligible beneficiaries are enrolled. CMS will focus future grassroots outreach efforts in these areas.

These beneficiaries are scattered throughout the country and are more likely to be isolated and members of minority groups. Because of these factors, they are traditionally hard to reach due to barriers posed by literacy, geography, language, or culture. Therefore, CMS' outreach and education initiatives are designed to identify remaining LIS-eligible beneficiaries who have not yet applied for the LIS or joined a plan; ensure that these beneficiaries complete the LIS application process; and encourage them to make an active choice to select a Medicare drug plan. CMS will strive to coordinate to the fullest extent possible with relevant federal, state and local partners on all outreach efforts.

To ensure that every person with Medicare who qualifies for the LIS gets subsidized Medicare prescription drug coverage, CMS outreach efforts to this critical population will be data-driven, with focus on identifying LIS-eligible populations at the state, county, community and individual level. Once these individuals are located, CMS will use a multi-pronged education and outreach campaign that will include direct mailings, telephone calls, and local outreach from community groups, intergovernmental partners, heath care providers and pharmacists. Many beneficiaries may be difficult to reach through traditional means. Therefore, CMS has special initiatives for both minority beneficiaries who live in urban areas and beneficiaries in rural areas who may be isolated from general community outreach efforts. For example, CMS is working with National Medical Association and the National Association for the Advancement of Colored People (NAACP) to reach areas with the greatest number of LIS-eligibles. CMS also is working with churches in rural and minority communities to continue to provide education on the LIS and Medicare's preventive benefits.

CMS plans to continue to review every source of available data to identify potential LIS-eligibles at the state, local, and individual level whenever possible. Coordination with SSA, the States, and other partners will be critical to the success of these efforts. For example, CMS continues to meet with a range of partners, including providers, pharmacists and community-based organizations around the country, including schools, small businesses, senior-centers, community centers, churches, and other faith-based groups. By working with such groups, CMS can continue to refine and implement a detailed plan that leverages combined resources to maximum effect, with initiatives such as enrollment events, health fairs, personalized counseling, and laptop distribution planned in targeted areas.

The CMS partnership with SSA is critical to reaching the LIS population. SSA will continue their extensive LIS outreach efforts through targeted education and application events, in addition to direct mailings and follow-up phone calls to likely LIS-eligibles. CMS plans to coordinate closely with SSA with personalized grassroots outreach.

In addition, the National Council on the Aging (NCOA) is using a CMS-funded grant to reach and qualify beneficiaries for LIS, and enroll beneficiaries. The project involves use of tailored, list-driven interventions to identify and enroll eligible beneficiaries. To date, a pre-test mailing of 15,000 (one percent of the 1.5 million names

identified thus far) has been completed, with 70 percent of those contacted applying for the LIS.

CMS continues to send deemed, auto, and facilitated enrollment notices on a monthly basis to beneficiaries who automatically qualify for the LIS. CMS also is updating a number of printed fact sheets and tip sheets to inform beneficiaries and our partners about the LIS, and these will continue to be disseminated through public and partner events. A number of earned media tactics are being considered to continue disseminating LIS messages through the media in targeted geographic areas, including public service radio announcements, TV/radio appearances by CMS spokespersons, and articles for newspapers and other community news outlets.

CMS Prepares for 2007

Since the initial start-up of the Medicare prescription drug benefit, CMS has provided plan sponsors with information on additional procedures and best practices that should be implemented in 2006 to meet our requirements. CMS expects these procedures and practices to be used in 2007. In preparation for its review of plan bids for 2007, CMS issued guidance on how organizations should bid and contract for the upcoming contract year. For example, in a letter to plan sponsors, CMS clarified policy statements developed in response to lessons learned during the Part D program implementation. The letter also restated existing program requirements and provided additional information about the PDP contract renewal process for 2007.

CMS also issued guidance on what is expected of plan formularies and transition policies. When reviewing plan formularies, CMS will ensure plans offer a comprehensive array of drugs that reflects best practices in the pharmacy industry, as well as current treatment standards. We expect plan formularies and benefit designs to include the full range of treatment options and, at the same time, reflect drug benefit management tools that are proven and in widespread use in prescription drug plans today. In reaching this goal, we also need to account for the specific needs of individuals who are already stabilized on certain drug regimens. An effective transition process for new enrollees must ensure timely access to needed drugs while allowing for the flexibility necessary for Part D plans to develop a benefit design that promotes beneficiary choice and affordable access to medically necessary drugs. We will review each plan sponsor's transition process as part of our plan benefit design review. CMS will continue to work with prescription drug plan sponsors as they prepare for 2007.

CMS Pivots to Prevention

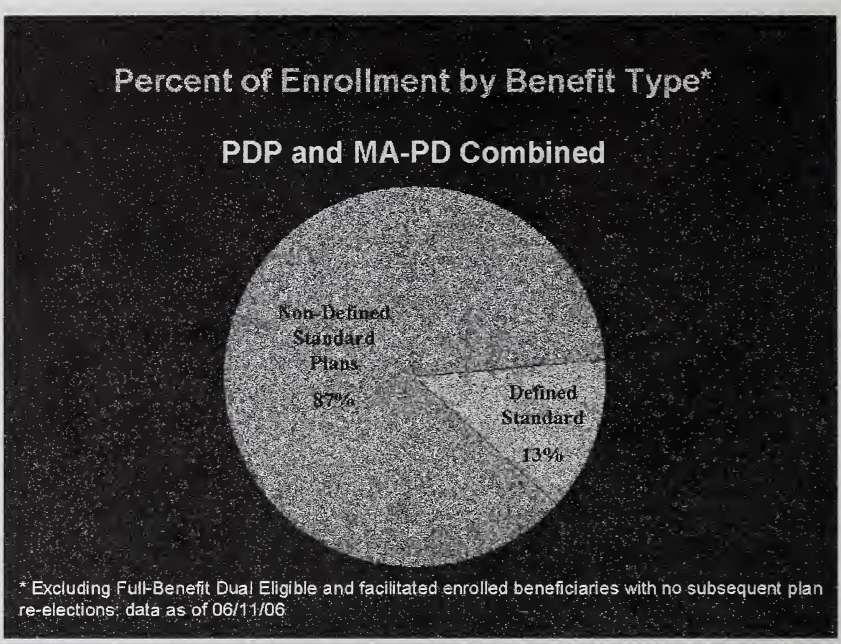
CMS is committed to promoting the appropriate use of Medicare preventive benefits, which include a number of new services. For example, in the last two years, Medicare has added a "Welcome to Medicare" preventive physical examination, cardiovascular blood screening tests, diabetes screening, and smoking and tobacco use cessation counseling. These preventive services help prevent the onset of a disease, provide an opportunity for an early diagnosis, and help providers work with beneficiaries on a disease management plan so complications can be avoided. However, not all people with Medicare take full advantage of these new services, which have the potential to save thousands of lives and avoid significant medical expenses in preventable medical conditions. To address this "prevention gap" CMS is collaborating with a number of partners, such as the American Heart Association, the American Cancer Society, and the American Diabetes Association, to develop educational materials.

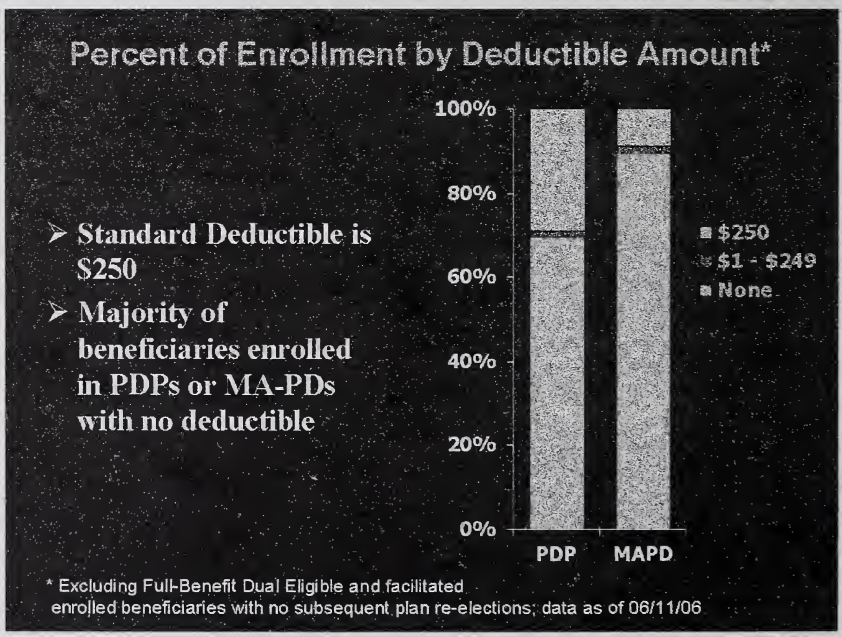
Since November 15th, 10,000 grassroots partners sponsored over 50,000 Medicare events and opportunities for people to get personalized assistance. More than 40,000 volunteers in communities across the country worked during this enrollment period counseling beneficiaries and sponsoring events to help people with Medicare.

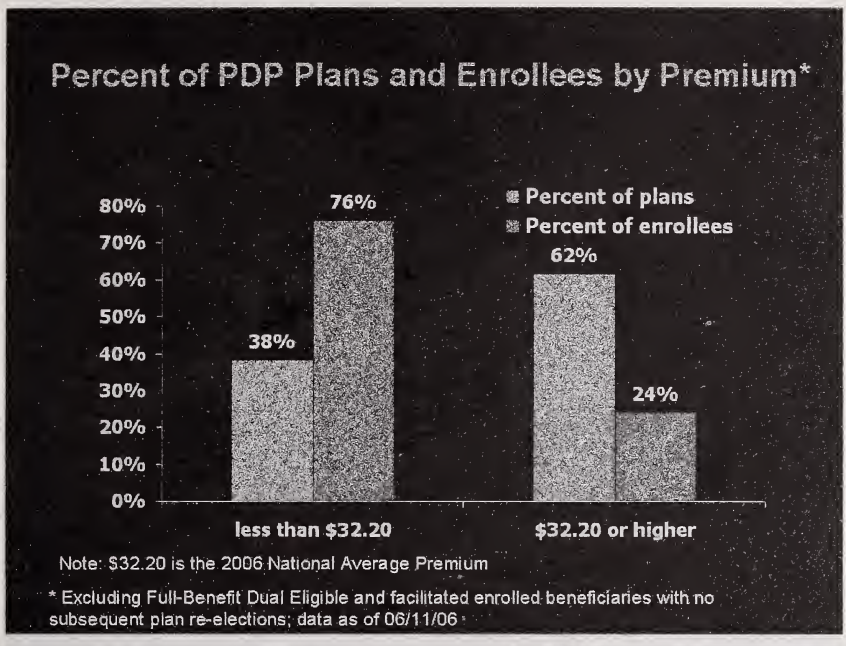
It's for these reasons that we're using the same grassroots networks and personalized support systems so successful in drug benefit enrollment to improve the effective use of other preventive benefits in Medicare. The steps we've taken to bring the drug benefit on-line, including community-based outreach, unprecedented partnerships, and much greater support for beneficiaries and caregivers, will be a permanent part of the Medicare program.

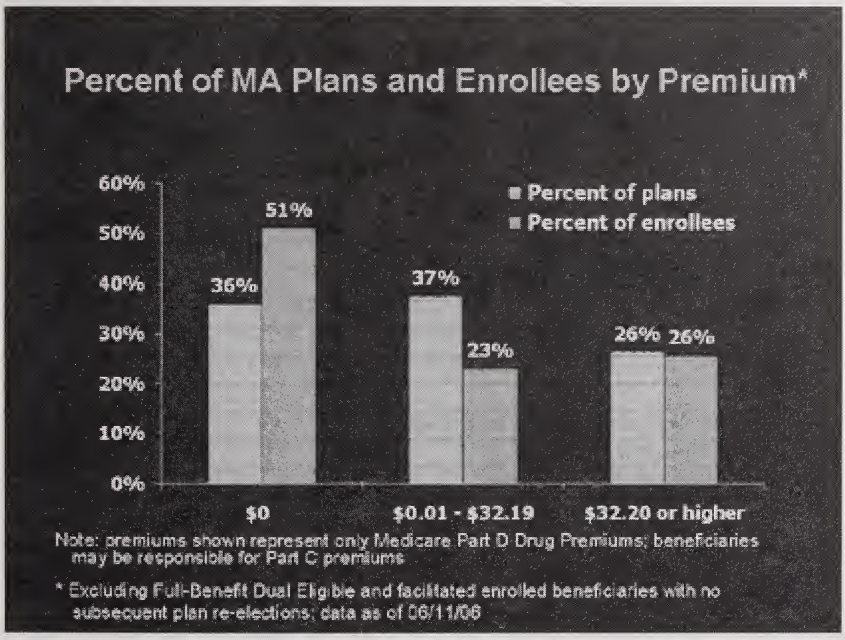
Conclusion

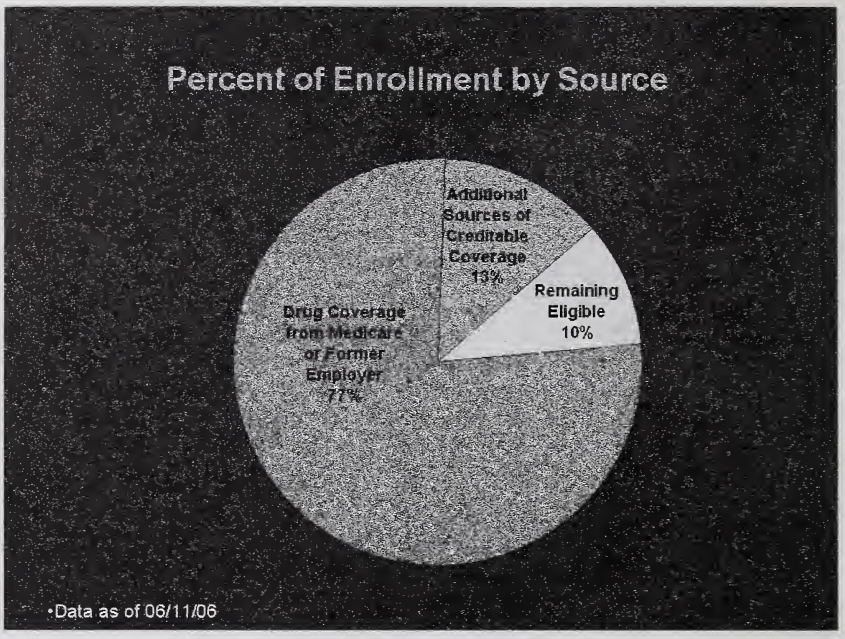
Thank you for the opportunity to discuss the Medicare prescription drug benefit and our activities to prepare for next year. While we are pleased that millions of Medicare prescriptions are being filled every day, we are going to continue working to ensure every person with Medicare can use their coverage smoothly. I am happy to answer any questions you may have.


Percent of Enrollment by Benefit Type*
PDP and MA-PD Combined
Non-Defined Standard Plans
87%
Defined Standard
13%
* Excluding Full-Benefit Dual Eligible and facilitated enrolled beneficiaries with no subsequent plan re-elections; data as of 06/11/06


Percent of Enrollment by Deductible Amount*
Standard Deductible is $250
Majority of beneficiaries enrolled in PDPs or MA-PDs with no deductible
100%
80%
60%
40%
20%
0%
PDP
MAPD
$250
$1 - $249
None
* Excluding Full-Benefit Dual Eligible and facilitated enrolled beneficiaries with no subsequent plan re-elections; data as of 06/11/06


Percent of PDP Plans and Enrollees by Premium*
80%
70%
60%
50%
40%
30%
20%
10%
0%
76%
38%
62%
24%
Percent of plans
Percent of enrollees
less than $32.20
$32.20 or higher
Note: $32.20 is the 2006 National Average Premium
* Excluding Full-Benefit Dual Eligible and facilitated enrolled beneficiaries with no subsequent plan re-elections; data as of 06/11/06


Percent of MA Plans and Enrollees by Premium*
60%
50%
40%
30%
20%
10%
0%
51%
36%
37%
23%
26%
26%
Percent of plans
Percent of enrollees
$0
$0.01 - $32.19
$32.20 or higher
Note: premiums shown represent only Medicare Part D Drug Premiums; beneficiaries may be responsible for Part C premiums
* Excluding Full-Benefit Dual Eligible and facilitated enrolled beneficiaries with no subsequent plan re-elections; data as of 06/11/06



Total Medicare Beneficiaries with Drug Coverage

As of 6-11-2006

Description	June (millions)
Drug Coverage from Medicare or Former Employer	
Stand-Alone Prescription Drug Plan (PDP)	10.37
Medicare Advantage with Prescription Drugs (MA-PD)	6.04
Medicare-Medicaid (Automatically Enrolled)	6.07
Medicare Retiree Drug Subsidy (RDS)	6.90
FEHB Retiree Coverage	1.60
TRICARE Retiree Coverage	1.86
TOTAL	**32.84**
Additional Sources of Creditable Drug Coverage	
Veterans Affairs (VA) Coverage	2.01
Indian Health Service Coverage	0.11
Active Workers with Medicare Secondary Payer	2.57
Other Retiree Coverage, Not Enrolled in RDS	0.10
State Pharmaceutical Assistance Programs	0.59
TOTAL	**5.38**

Mr. MCDERMOTT. Madam Chairman.

Dr. MCCLELLAN. As a result, premiums overall were less than $24 a month.

Mr. MCDERMOTT. Point of information. Could you explain what PDP and MAPD stand for?

Dr. MCCLELLAN. Sure. PDP is prescription drug plan. That is the stand-alone prescription drug plans you can add to your Medicare benefits. Medicare Advantage or the private health plans in Medicare offer a comprehensive set of benefits for people in the program. With these lower costs, means that there are billions of dollars in more savings from beneficiaries and taxpayers than the Secretary mentioned. MAPD is the Medicare Advantage drug plans.

Mr. MCDERMOTT. Thank you, Madam.

Dr. MCCLELLAN. Sure. Seniors making choices have been very important in getting lower costs and better benefits in Medicare. Altogether, if we add up the numbers, as you can see on the last table that we provided, about 38.2 million Medicare beneficiaries are now receiving prescription drug coverage. In that number about 32.8 million have coverage from Part D-related sources, and about 5.4 million have coverage from other sources, including the Veterans Administration, or primary coverage from an employer because they are working past age 65, as well as State prescription drug programs that are not yet combined with Medicare Part D. Almost 10 million low-income beneficiaries are getting comprehensive coverage for little or no cost.

Breaking down these numbers further, about 10.4 million people with Medicare have enrolled in stand-alone prescription drug plans, in addition to their other Medicare—traditional Medicare coverage. In addition, 1.2 million beneficiaries have newly enrolled in Medicare Advantage health plans to get the new drug coverage. This is unprecedented rapid growth in the Medicare Advantage program. Since the open enrollment period began in November, enrollment in Medicare Advantage plans has increased by 26 percent in just 6 months.

Of the approximately 16 million people with Medicare who did not have drug coverage for the whole year before the benefit began, 11.6 million now have coverage, and many millions more beneficiaries now have more comprehensive and secure drug coverage than before.

As the Secretary mentioned, about 10 percent of beneficiaries, that is 4.4 million, did not enroll in drug coverage yet. The vast majority of these beneficiaries, an estimated 3.2 million, more than 75 percent, are eligible for the low-income subsidy. These beneficiaries can enroll any time through the end of the year with no penalty. This is a population that has been historically hard to reach, but thanks to our grass-roots partnerships, we are reaching them more effectively than in past Federal programs targeted to lower-income beneficiaries. As you will hear today, we are expanding these efforts based on our data-driven outreach strategies and successful programs to reach all of our beneficiaries. The Medicare drug benefit is already making a historic difference in the health of seniors. It is doing so at a much lower cost than expected. As the Secretary said, we intend to build on the successes of the pro-

gram, continue to improve it so that we have the potential for even better health at a lower cost in the future.

Thank you very much, and we would be glad to answer any questions that you may have.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much.

Before I pose my question, I do want to congratulate you on the most aggressive effort to implement a Federal program nationwide that I have ever witnessed in my 23 years here in Congress. The building of partnerships, right down to the church level, is literally unprecedented. I think it explains why we have the highest level of participation after a mere few months that we have ever had in any Federal program, and I really commend you on that.

In talking with, and you will hear him testify later—Mike Starkowski from Connecticut; I got some sense of the degree to which you were responsive, as the problems did develop within the first few months and as there have been larger issues to discuss since then. I have never seen a situation in which the Secretary himself and the administrator himself were on the phone almost daily with the States to listen, to learn and to plan action. For that reason, millions of seniors across America are enjoying the benefits of this important program.

The other thing I just like to comment on is my interest in our experience from having laid out a basic program. Eighty-seven percent managed to get the information they needed to choose something other than the basic benefit. I can tell you there were seniors that were thrilled to have a $7 option for a very basic benefit since they don't use drugs anyway, and can rely on that, and that at other times in their retirement take a more expensive benefit. Not only does this allow the senior to tailor the plan to their needs, and, thereby, carefully harbor their financial resources, but it allows them to expand that coverage as their needs change over time. I thank you for your good work on that.

My question is, are you going to have the resources to fund the same kind of partnership capability in the next round of sign-ups and changes that you have had in this round? Because I think building on the knowledge base that you developed the first time is very important, as people change plans the first time round, or some sign up that hadn't signed up. The other thing that I think is equally important, because I have heard you talk about this, Dr. McClellan, is that you want to use this grass-roots network to now help move people from thinking about drugs to thinking about health and wellness and eventually wide chronic disease management.

If you could give me your perception of where you are in the funding of the resources to support, once again, a really aggressive communications capability with seniors and many organizations deeply embedded in our communities, I want the answer to that.

Secretary LEAVITT. I will comment on that and then ask Dr. McClellan to add to it. The spirit of the partnership clearly continues, and the network of caring that I spoke of has been developed. It is our anticipation that as we roll in the second plan year, we won't be dealing with 42 million people as we were the first time around, and therefore, while the spirit and the partnership will remain, the breadth of the challenge, the breathtaking chal-

lenge that I referred to otherwise, will be somewhat different. We will be not just waiting for the second plan year. We are continuing with those who are low-income to try to enroll them now without penalty because that is the group we are focused primarily on. We are also enrolling people as they turn 65. As you indicated, our purpose is to begin rolling into prevention. The resources are in place to do those things.

Dr. MCCLELLAN. To do all this we have built the kind of support we had in this year's open enrollment process into our ongoing budget expectation, so we are going to provide the same kind of grass-roots network support, we are going to provide the same kind of support to the State health insurance assistance programs like the terrific one in Connecticut that got their own buses and found some very innovative ways to reach beneficiaries. We are going to continue all that into the next year.

I do think there is a tremendous opportunity to use the same kind of support for our individual beneficiaries that helped them pick a drug plan that worked for them at a much lower cost than expected, to help them take advantage of our preventive benefits. Half of our seniors don't use our cancer screening benefits, for example, and we can now give them personalized information on which benefits are available for them, that are recommended for them, that they haven't used. We are going to work with these same partners to build that spirit of personalized involvement in health care and staying well into the program going forward.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. I would say that this is the—for the first time, and remember how old the disability benefit program is in America, it goes way back—it is the first time we have been able to successfully link with our disabled seniors to refer them into other programs, other Federal benefits. It became the first one-stop benefit advisory capacity that we have had, and that has been a godsend to our disabled population for that reason. I thank you for that. I would now like to recognize Mr. Rangel.

Mr. RANGEL. Thank you, Madam Chairlady. At this time I would like to yield to the gentleman from Georgia, Mr. John Lewis.

Mr. LEWIS OF GEORGIA. Mr. Rangel, thank you very much for yielding. Mr. Secretary, I must tell you that I am very concerned and really disgusted by an article that appeared in the Atlanta Journal Constitution this morning called Cabinet Official is Primary User of CDC Jet. This jet leased by the Centers for Disease Control and Prevention (CDC) is kept on stand-by in Cartersville, Georgia, only about an hour from CDC, or from the city of Atlanta. It is meant to be used for public health emergency and what is called a significant event.

The article suggests, Mr. Secretary, that you used this jet on 19 trips to visit more than 90 cities, and most of the travel was to promote the new Medicare prescription drug plan and to make appearances at State flu, pandemic flu plan meetings. Mr. Secretary, you used the jet to do really public relations for the President for his confusing and complicated prescription drug plan. I think this is unbelievable, irresponsible, and just dead wrong. The jet is supposed to be used for emergencies. For example, it was used by the CDC this year to transport life-saving antidotes.

Mr. Secretary, I want to know why you used the jet, and it was to supposed to be used to save lives, at a cost of $3,000 an hour, when other commercial planes were available that you could have used. I understand that twice this year, so far, that you used the jet—traveling on this jet while CDC had cases—anthrax case, a person had been exposed to radiation material. In the second case, the CDC had to use another plane. Again, Mr. Secretary, this is irresponsible when you visit cities that are accessible by commercial airline. Madam Chair, I would like to submit this article for the record.

Mr. LEWIS OF GEORGIA. I just think there should be some explanation, Mr. Secretary. It is bad enough that you have a bus that is traveling around the country to promote Medicare Part D, but Part D—but, Secretary Leavitt, you were flying around to meet the bus, and that would be fine. Your flying on a CDC emergency plane, that is disgraceful. That is a waste of resources. I would like an explanation. Again, Madam Secretary——

Mrs. JOHNSON OF CONNECTICUT. The article will be submitted for the record.

[The article follows:]

Report: CDC 'emergency' jet being used primarily by cabinet secretary From asap 6/15/06

ATLANTA—A jet leased by the Centers for Disease Control and Prevention is supposed to be used for emergencies, but the Atlanta Journal-Constitution reports that's not what it's being used for. The Journal-Constitution analyzed the Gulfstream III's flight log and found that the 14-seat aircraft has been used primarily by Health and Human Services Secretary Mike Leavitt to attend news conferences promoting the new Medicare prescription drug plan and meetings with state officials over their flu pandemic plans.

COST TO TAXPAYERS

So far in 2006, the aircraft has cost taxpayers $2.1 million, with at least $720,000 of that spent on flight hours used by Leavitt, according to CDC and HHS officials.

LEAVITT'S 19 TRIPS

Since January, Leavitt has taken the jet on 19 trips to visit more than 90 cities, his spokeswoman told the newspaper. During the same period, CDC officials said they had used the aircraft to respond to three emergencies and conduct three training exercises. The Journal-Constitution reported that during two emergencies, the CDC was forced to use another plane because Leavitt was using the Gulfstream.

LEAVITT'S RESPONSE

Leavitt's spokeswoman, Christina Pearson, told the newspaper his use of the jet is appropriate and in compliance with Federal guidelines.

Mrs. JOHNSON OF CONNECTICUT. I would like to recognize the Secretary to respond.

Secretary LEAVITT. Mr. Lewis, I acknowledge your concern. Let me just say I am deeply appreciative of the fact that the Congress did make that available for this kind of a circumstance. I simply could not have accomplished in the last 6 months the task, the breathtaking challenge, that was in front of our agency not just to implement Part D, but also to deal with the avian flu pandemic. Much of that travel was related to the pandemic preparedness, and I could not have accomplished it. I have appreciated the Congress making it available and will use it in accordance with the rules that are laid out. The good news is we accomplished the task, and otherwise I don't know that we could have.

Mr. LEWIS OF GEORGIA. I think—Mr. Secretary, have you seen the article?

Secretary LEAVITT. I haven't. The article is ostensibly accurate. It didn't reflect that I was on commercial flights 65 times, and that I used commercial aircraft whenever I could. It did reflect the fact that I was in 70 cities using it, and essentially it was for both pandemic and Medicare. That is correct. I am deeply appreciative of the fact that the tool was there. Running a department with 70,000 employees and $700 billion is a challenging task, and when you add the Medicare Part D to that and the avian influenza and needing to be in 40 States in about 120 days, you need that kind of a tool, and I am appreciative of the fact that the Congress made it available specifically for this kind of event.

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Mr. LEWIS OF GEORGIA. In doing so, it is at your discretion. Do you think your discretion was the best?

Secretary LEAVITT. Actually, Congressman, the plane has been an asset of CDC for some time.

Mr. LEWIS OF GEORGIA. Did you use the plane to promote a prescription drug Part D on the Medicare for the most part?

Secretary LEAVITT. The job I was given by the Congress and by the President was to assure that seniors had an opportunity to enroll in this, and we accomplished it. The good news is that nearly 90 percent of seniors now have prescription drug coverage, and they did not before. I am proud of what we have done, and I don't believe we could have accomplished—I could not have accomplished my job in the last 6 months——

Mrs. JOHNSON OF CONNECTICUT. I would like the record to note that the Secretary's presentation on the pandemic issue in Connecticut was extremely helpful, bringing all agency people, public and private people together to begin to see how do we plan for this. That is one of the things he has been using that plane for, not reflected in that article. It is important that our National spokesman get out there to where the people are; otherwise, they don't benefit from the programs we are funding and the efforts we are making to plan for the future. Mr. Shaw.

Mr. LEWIS OF GEORGIA. Madam Chair.

Mrs. JOHNSON OF CONNECTICUT. Your time has expired. I recognize Mr. Shaw because—excuse me——

Mr. LEWIS OF GEORGIA. I am not concerned—Madam Chair——

Mrs. JOHNSON OF CONNECTICUT. Excuse me. You had your entire 10 minutes. There are other Members who want to question the Secretary before he leaves, and I am going to give them the opportunity to do that. You did not put your article in the context of his responsibilities.

Mr. LEWIS OF GEORGIA. Let me explain for the bird flu. Madam Chair.

Mr. DOGGETT. Madam Chair, I ask unanimous consent for the gentleman——

Mrs. JOHNSON OF CONNECTICUT. There is objection. Mr. Shaw has already been recognized, and I asked the Committee to be respectful of the Secretary's time and of the other Members on the Committee. Mr. Shaw.

Mr. SHAW. Madam Chairman, I must say that I am somewhat taken aback by the comments from my friend from Georgia, and whereas they may have been well intended, they have been misdirected. The purpose of these planes was to make the best possible use of the Secretary's time and the resources of his, of the Administration, in order to get the word out that this drug plan did put forth some great benefits. I can tell you, seeing the rhetoric that was in my congressional district and what was going on down there is just people trashing the plan, saying it was too complicated to even figure out when 85 percent of the Americans that signed up said, yeah, they understood it—that is our seniors. They understood it. Sure, it took a little bit of time. It took a little bit of time because the private sector offered so many choices, and that is exactly what we wanted.

I remember very well the debate on this bill going through, and I was hearing from the critics of the drug plan nobody is going to be out there. There aren't going to be any plans out there. I can tell you I think in my congressional district there were over 40 that were available. Did that add to the confusion? Yes. It is like going into an ice cream parlor and seeing you have a good 20 or 30 flavors to pick from. that doesn't keep you out.

The seniors were very good in going through and picking out the plans, and the administration was superb. I have seen the Secretary in my congressional district in putting forth and putting publicity and shining a light on the fact that there is a plan out there that is a great benefit to the seniors.

I might say, too, that about 85 percent of the seniors who have signed up are also very pleased with the plan. I can tell you any time 85 percent of the people are satisfied with a Federal plan, that is a record. I think it is a great program, and I am certainly glad that it was passed, and I am glad that the seniors are smart enough to see through the naysayers and sign up for it.

Now, Mr. Stark, much to his credit, just said nobody is advocating elimination of the plan. That is good. The question is, too, and one that I hope will come back before the Congress, and that is what are we going to do with the penalty? Are we going to penalize the seniors because of the negative information they got during the sign-up period? I hope not. I would hope that Chairman Johnson's bill that would eliminate the penalty would be enacted by the Congress.

Secretary, I have just a short question for you. What do you see in the atmosphere out there right now? What are people thinking about the program and how it is working?

Secretary LEAVITT. As you might expect, Congressman, we went through a period where people had heard nothing about it. Then they became curious. Then they became—then there was a period of not understanding, and we have gone through a period of education. Now we are in a period of what I would characterize as just gratitude. People have not only saved money, but they have the drugs they need when they need them. They will have the drugs to stay healthy. It has given them a peace of mind they otherwise would not have had.

This has changed the atmosphere in health care like nothing else has in 40 years. This is the most significant event in health care

in that entire period of time. We are no longer as a country just thinking about health care as treatment. We are thinking about it as a means of keeping people healthy. People appreciate the benefit and have found it extraordinarily helpful.

Mr. SHAW. Mr. Secretary, I have talked to a number of druggists down in south Florida, and they are finding now that the seniors are filling their prescriptions, not half filling them. We had a terrible problem of seniors cutting their pills in half and things of that nature and ended up back in the emergency room, and that seems to have subsided a great deal. I think that the savings we are talking about that we would get on the side of medical treatment is being offset by the cost of providing the seniors with the prescriptions that we can take in accordance with instructions from their physicians.

I would like to add one point, too, about the question of the use of jets. Congress goes on a number of fact-finding trips throughout the country, and we use Federal jets. We don't use commercial flights when we can get a—when a jet is available to us for that type of travel. I think it is a little hypocritical for us to sit here and criticize the administration or a member of the administration for taking a Federal jet, federally-paid-for jet, and making the best use of his time.

I know for a fact you could not have possibly covered covered nearly the territory you covered if it were not for that jet being available to you. Just like when Congress travels, we couldn't hit all the countries, and we will do like one country a day, a capital a day, and never even see the country hardly, but we will make maximum use of the time we have in order to travel abroad. I think it is a good thing, and I encourage you to keep it up, and thank you and yield back.

Mrs. JOHNSON OF CONNECTICUT. Mr. Herger.

Mr. HERGER. Thank you, Madam Chair. Mr. Secretary Leavitt, it is great to see you again. The last time I saw you was when you were visiting my rural northern California district, almost all of which is not accessible to commercial planes, and we are helping my constituents sign up for the prescription drug benefit.

You will be happy to hear that on March 31st, our local newspaper in Redding, the Record Searchlight, printed a letter to the editor from one of my constituent, Ms. Adriana Drew, who talked about her grandfather signing up for the benefit. She wrote, quote, after everything bad I had heard about the Medicare prescription drug plan, I worried when my granddad signed up for it last fall. His medication costs were more than $400 per month, and from what I had seen online, he wouldn't save much. When I tried to help him choose a plan, he seemed insulted. He said, Owens Pharmacy and Medicare had answered his questions, close quote.

Adriana continued. She changed her mind when she saw how the plan was helping her grandfather. Quote, last week I was there when his medications were delivered to the door, and I saw the bill. He is now paying a fraction of what he paid before, and he gets 90-day supplies instead of 30, so I figure the devil must be in the deductible. the plan he chose has no deductible. The same is true for most of his friends at the senior center, and his premiums are

$7 less per month than what was predicted on the news, close quote.

She concluded by asking why news reports were so discouraging about the benefit, noting that their negativity was hurting senior citizens.

Mr. Secretary, we have all heard from people who were reluctant to sign up because they were concerned that the plan would be too complicated. Does this account of my constituent in northern California, in Redding, reflect the kind of feedback you have received from senior citizens who have actually signed up?

[The aforementioned article follows:]

March 31, 2006

Drug plan is a great deal

After everything bad I'd heard about the Medicare prescription drug plan, I worried when my granddad signed up for it last fall. His medication cost more than $400 per month, and from what I'd seen online, he wouldn't save much. When I tried to help him choose a plan, he seemed insulted. He said Owens' Pharmacy and Medicare had answered his questions. So I backed off.

Now the other shoe has dropped. Last week I was there when his medications were delivered to his door, and I saw the bill. He's now paying a fraction of what he'd paid before, and he gets 90-day supplies instead of 30. So I figured the devil must be in the deductible. But the plan he chose has no deductible. The same is true for most of his friends at the senior center. And his premiums are $7 less per month than what was predicted on the news. An online survey shows that more than 80 percent of seniors polled like the plan, and only 5 percent had unresolved problems. The proof is in the pudding, and this pudding is good. So why are news reports still discouraging seniors from signing up? I learned that those who don't sing up by May 15 may end up paying a penalty.

If readers respond to my letter, please use verifiable facts, not emotions. Don't call me names and say I don't understand the nuances. I'm college-educated, successful in business, and I read everything. I get the nuances. What I don't get is why all the negativity that hurts senior citizens?

Adrianna Drew
Anderson
The Redding Searchlight Newspaper, *www.Redding.com*

Secretary LEAVITT. Mr. Herger, I have heard that story in different iterations hundreds of times. I have sat by the side of seniors as they, who had been paying $400, $500, and $600 a month, and when they walked out, they would have $20 or $25 a month. It completely changed their lives financially.

I have met seniors who had total incomes of $1,200 or $1,500 a month, and who were spending a third or half of it on prescription drugs, only to have it essentially, hand back half their income. It changes their lives in a very positive way. I was in a pharmacy in Florida when I met a pharmacist who was helping a customer. He said to his customer, didn't the doctor prescribe osteoporosis medicine for you? She said, yes, but I can't afford it. He said, you can now. They signed up for a plan. It has changed their lives, and I can tell you that with not just honesty, but with real fervor, because I have seen it, I have felt it, I have heard their expressions. I have seen, frankly, tears of joy not only in their faces, but in the faces of their families.

Mr. HERGER. Again, Mr. Secretary, I want to thank you for the incredible job you have done, and Dr. McClellan and the Administration, despite all the negativity. I am grateful that you were able to locate a plane that you could visit a rural area like Redding, California. Again, I thank you, and my constituents thank you.

Secretary LEAVITT. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. I have heard the statutory language defining how the Secretary may or may not use the plane. I would like to submit it for the record.

[The information follows:]

LEGISLATIVE AND REPORT LANGUAGE REGARDING THE ABILITY OF SECRETARY LEAVITT TO USE THE CDC PLANE FOR EMERGENCY SITUATIONS (as submitted by Rep. Pete Stark, with emphasis added)

Conference report on FY 2006 Labor-HHS-Education Appropriations Act (H.R. 3010, H.Rept. 109–337; PL 109–149)

SEC. 227. In addition to any other amounts available for such travel, and notwithstanding any other provision of law, amounts available from this or any other appropriation for the purchase, hire, maintenance, or operation of aircraft by the Centers for Disease Control and Prevention shall be available for travel by the Secretary of Health and Human Services, the Director of the Centers for Disease Control and Prevention, and employees of the Department of Health and Human Services accompanying the Secretary or the Director during such travel.

From the Statement of Managers:

DEPARTMENT OF HEALTH AND HUMAN SERVICES TRAVEL

The conference agreement includes a new provision granting authority to the Secretary to use, at his discretion, charter aircraft under contract with the Centers for Disease Control and Prevention (CDC). The Secretary has significant operational responsibilities in times of emergencies and in the days following such emergencies. The Department is the primary agency for directing public health and medical services in response to significant events. Due to the unpredictable nature of such events, the conferees believe the Secretary must be in a posture to respond and communicate as an event is unfolding. Yet, existing travel limitations on the Secretary make this extremely difficult. The availability of CDC's charter aircraft will allow the Secretary to immediately return to Washington or rapidly move to another location as the situation dictates, at the same time being able to securely communicate with and direct the Department.

The conference agreement also extends this authority to the Director of the Centers for Disease Control and Prevention. The conferees understand that, due to existing restrictions, the Director on a number of occasions has not been able to accompany employees of the Agency responding to public health emergencies.

The conferees expect the Secretary and the Director of CDC to exercise this authority in an economical and judicious manner. The conferees request that the Secretary report to the Committees on Appropriations of the House and Senate regarding the use of this authority in the annual justification of estimates for the Appropriations Committees and at the end of the third quarter of each fiscal year.

Mr. STARK. It makes very clear that he is only authorized to use this plane in times of emergencies. It says nothing about going on public relations trips. Mr. Secretary, you are asked to submit an annual justification to the Appropriations Committee. I would suggest to you, and ask you to submit it to the Committee in writing. If we could have the flight logs for the plane during the times you used it, we could compare it to the emergencies that you seem to think might have existed. It will certainly help the Appropriations Committee determine how—because this plane was clearly designed for the (CDC) to be used as a Medevac plane and not for public relations junkets.

I might further add that while Members of Congress often do take Federal aircraft when they are over—going on overseas trips, for the most part, when they go golfing, they are able to get lobbyists to provide private jets for them very frequently. I am sure the Secretary could have found these same lobbyists who would have stepped right up and provided care, particularly from the pharma-

ceutical companies who wrote this bill. I am sure that they would have been glad to fly you around, Mr. Secretary, at no cost to the taxpayers, because you have already stolen money from the taxpayers in designing the Part D Medicare bill.

Further, this idea that this Chair's bill for waiving the penalty will do much, I see no reason—and, Dr. McClellan, I would like to have you submit in writing why it would not be a good idea to add to this waiving of the penalty, opening the enrollment for all people and keeping it open until the end of the year. This would give us an additional 6 months for the people, and we find that 25 percent of the low-income people are all that has been enrolled. We have millions of people out there who could benefit from added time. As I said, it would possibly be heard from Congressional Budget Office (CBO) that it would cost $2 million or $2 billion to keep the enrollment open, and that seems very small amount out of the a trillion dollars you are going to spend. I would like you to comment in writing as to why we should not add opening enrollment to waiving the penalty. This would be a great step and certainly much more proficient. Can we have those documents? Will you respond?

Dr. MCCLELLAN. You can. I would be happy to respond right now.

Mr. STARK. Mr. Secretary, can we have flight logs?

Secretary LEAVITT. Absolutely.

Mr. STARK. Thank you. We will look forward to that.

[The information follows:]

TRAVEL REPORT
JANUARY 11, 2006 TO JUNE 2, 2006
Completed Trips

Traveler's Name Organization/Title	Purpose of Trip(s)	Destination(s)	Indicate if Personal, Political, or Official travel	Date	Cost[1]
Mike Leavitt Rich McKeown Suzy Defrancis Christina Pearson Jack Kalavriitinos	Avian Flu	LA, VT, WV, RI, GA	OT	1/11-13	$25,500
Mike Leavitt, Kerry Weems, Calise Munoz, Tom Barker, Jeff Flic, Christina Pearson, Ellen Field	Medicare	OR, CA, NV, WI, OH, IL, MO, AR	OT	1/18-21	$72,000
Mike Leavitt, Rich McKeown, Tom Barker, Dennis Smith, Brian Cresta, Charlie Johnson	Medicare	MA, ME, NJ, KS, OK, FL	OT	1/25-27	$42,000
Mike Leavitt, Tom Barker, Dr. Agwunobi, Suzy DeFrancis, Christina Pearson	Avian Flu, Medicare	CT, IA, AZ, NM, WA	OT	2/2-4	$42,750
Mike Leavitt, Julie Gerberding, Jack Kalavritinos	Avian Flu	FL, OH, NV	OT	2/16-18	$50,637
Senior Officials[2]	New Orleans, Medicare, Avian Flu	LA, AL, FL, NE	OT	2/21-23	$28,600

[1] Costs are based on the estimates provided in each Request for Approval of Use of Charter Aircraft justification attached.
[2] Names of the Senior Officials are provided in each Request for Approval of Use of Charter Aircraft justification attached.

Senior Officials[3]	Avian Flu	SC, UT, CO, MO	OT	3/2-3/3	$26,295
Mike Leavitt, Julie Gerberding, Ed Brink, Nicole Smith, Tom Barker, Joe Nunez, Tom Barker, John Agwunobi	Avian Flu	SD, ND, WY, MT	OT	3/8-10	$53,250
Mike Leavitt, John Agwunobi, Tom Barker, Christina Pearson, Stewart Simonson, Bill Raub, Jack Kalavritinos, Christina Pearson, Bill Raub,	Avian Flu	PA, IL	OT	3/17	$24,000
Mike Leavitt, Rich McKeown, Kerry Weems	Avian Flu, Medicare	VA, IN, WI, CO, UT, ID, TX	OT	3/23-27	$49,050
Mike Leavitt, Rick Campanelli, Tom Barker, David Brailer, Ellen Field	Avian Flu, Medicare	OR, CA, NE	OT	3/30-31	$53,250
Senior Officials[4]	Medicare	KY, OH, IA, SD, MN,	OT	4/3-5	$33,150
	Avian Flu, Medicare	TN, IL, NJ, NY, PA	OT	4/10-13	$45,150
	Medicare	CA, AZ	OT	4/18-21	$37, 750
	Medicare	TN, TX, AR, LA, VA	OT	4/24-25	$28,666
	Medicare	GA, IN, FL, AL, MI	OT	5/7-10	$47,250
	Medicare	NJ, PA, CT	OT	5/11-13	$24,750
	Avian Flu	NJ, KS	OT	5/31	$23,250
	New Orleans Healthcare Infrastructure/ Emergency Preparedness	LA, GA	OT	6/1-6/2	$ 6,300
Total				19 trips	$713,598

Mr. STARK. We will hear later from an insurance commissioner, and while he praises the program, two of his points are that we should extend the initial open enrollment period through the end of 2006 and increase funding for the State Children's Health Insurance Programs (SCHIPs). I hope you will get copies of his suggestions. He also is very concerned about cross-selling and the fact that insurance commissioners aren't able to stop that.

Let me suggest to Dr. McClellan that we were able, and we do appreciate, because last year we didn't have a chance, to see the proposed 2007 Medicare handbook. I do have a couple of problems, and I guess I need some commitment as to the editorial content of these books. It seems to me that well above 80 percent of the Part D programs retain what we refer to as a doughnut hole. Is that correct?

Dr. MCCLELLAN. All beneficiaries have options of choosing a plan that have no doughnut hole——

Mr. STARK. 80 percent of them do contain a doughnut hole. Wouldn't it be a good idea to explain the doughnut hole in the booklet? There is no explanation. There is a chart back on page 45, and then there is an appendix. There is no clear explanation of what the doughnut hole is. I hope we could have a commitment that in fairness this proposed 2007 booklet would clearly explain so that people don't wake up one morning and suddenly find that the cost of their drugs have quadrupled. Would you commit to me to see that we have a clear expansion of that?

Dr. MCCLELLAN. As always, Congressman Stark, I am happy to commit to you that we take your comments on this early draft of the handbook and consider it as we find the most effective ways to give our beneficiaries information. Beneficiaries get monthly

statements about where they are in relation to the doughnut hole——

Mr. STARK. I am talking about before they sign up so they know what they are getting into and what they might anticipate——

Dr. MCCLELLAN. That is all included in the information we have on the plan finder that millions of beneficiaries have used——

Mr. STARK. That is not online yet. As I say, I think it should be in the booklet. Next I notice in the booklet that we are going to have medical savings accounts next year. Can you tell me how much money we are going——

Mrs. JOHNSON OF CONNECTICUT. Mr. Stark, your time has expired. I don't like cutting off Members, and particularly the Ranking Member of the Subcommittee, but the Secretary's time is limited. Many people came on time to this hearing, and I am sorry——

Mr. STARK. Madam Chair, you are quite right. I just wanted to know how much they are planning to have medical savings accounts, what the payment would be. I am sure that all the Members would like to know.

Mrs. JOHNSON OF CONNECTICUT. I am sure we will come back to that issue. Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair. Before I allow Dr. McClellan to answer Mr. Stark's previous inquiry, I want to add my appreciation to those already expressed by Members of our panel for the excellent job that the bureaucracy and the Department of HHS and CMS headed up by the two witnesses we have before us today did in this effort.

Unfortunately I have not always been able to compliment the bureaucracies at the Federal level over the last 12 months or so, but in your case, it was just an amazing accomplishment that you all did. I know personally from talking with each of you, you have just worked tremendously long hours and spent many, many hours mulling the very questions that are being posed today, trying to reach the best answer for the most number of people, and the result, I think, speaks for itself. It is very, very positive. I want to add my thanks to you for the job that you have done. Please don't quit your posts. We need you in this Government. Dr. McClellan, before I get to my question, would you like to respond briefly to Mr. Stark's original inquiry?

Dr. MCCLELLAN. We expect MSA plans to be available using the same kind of payment approaches that are available in Medicare Advantage plans today. And——

Mr. STARK. A thousand bucks?

Dr. MCCLELLAN. I am sorry, what was the question? The savings account will look a lot like the Medical Savings Accounts (MSA) and Health Savings Accounts (HSA) plans that are being used by millions of people in the United States today, but until now have not been available to Americans over age 65. I think a lot of people are going to be continuing in these programs——

Mr. MCCRERY. The actual question I was referring to was keeping open the enrollment for the rest of the year, that Mr. Stark asked about.

Dr. MCCLELLAN. We have made special enrollment periods available for beneficiaries with limited means and will be making

available for beneficiaries in areas affected by Hurricane Katrina and Hurricane Rita. We will have additional details out on that later today. Also, I want to emphasize the importance of the deadline. You heard from the Secretary about how we saw a huge surge in enrollment before May 13, 2006 when 2.2 million people signed up in the last 2 weeks of the program. We handled it effectively. As a result, we have 90 percent of people with Medicare in drug coverage now and only about a million who would be subject to a penalty this year. For reference, that is significantly lower than the 3.3 million Medicare beneficiaries who would be subject to a late enrollment penalty for Medicare Part D if and when they sign up for that. We have better administration for the new program than the Part D program that has been around for 40 years.

Mr. MCCRERY. Both programs are very generous, part B and Part D. The subsidies provided by the Federal Government in both programs are so generous. It is remarkable that 100 percent of the patients don't sign up, and I suspect we will get close to that before it is over. I want to address one comment that my friend from California, Mr. Stark, made about—we have already stolen from senior citizens. I think that is what he said. I assume he is referring to not allowing the government to negotiate, directly, prices for drugs under the Part D program. There was a study, I think, that CMS recently did pointing out that seniors can save up to 71 percent under the Part D program as it exists now, the cost of their drugs compared to what they were paying without Part D coverage. Is that right? Given that, do you think that we are doing a pretty good job letting the market compete and bring down prices, and would it be wise to shelve that and go to government negotiation? Mr. Secretary.

Mr. LEAVITT. The way competition works, and it is well demonstrated by the effects of this program, we initially anticipated the $37 senior citizen savings to be able to determine over a 10-year period to save money—they save money because of this program with the competition in the marketplace.

Mr. MCCRERY. This is something where we will save billions of dollars because of this program.

Mr. LEAVITT. That is correct.

Mr. MCCRERY. Because of this competition in the marketplace. Thank you very much.

Mrs. JOHNSON OF CONNECTICUT. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair. Thank you, gentlemen, both of you, for all you have done to make prescription drug coverage available to literally millions of seniors like the elderly lady who came up to me in a restaurant a couple of weeks ago literally with tears of joy, so grateful for prescription drug coverage. She happened to be a low-income senior living on Social Security and a very limited pension, and this meant the world to this lady who suffers from a heart condition and several other maladies. Thank you for all you have done, both of you gentlemen.

Dr. McClellan, my question is addressed to you. As Yogi Berra put it years ago, probably seems like déjà vu again, because we had a colloquy on May 3rd about State reimbursement for the elderly dual-eligibility problems; and, as you know, as you said at that time, Minnesota was one of the many States that stepped in with

Medicaid dollars to fill the gaps when there were initial problems with the dual-eligible population seniors and people with disabilities who are eligible for both Medicare and Medicaid. At that hearing, you stated that CMS will promptly reimburse States that had stepped in to fill the gap with dual eligibles as long as they have submitted all of the proper information.

I just recently talked to the Governor of Minnesota and he assured me that the State of Minnesota within the next several weeks will have submitted all of those forms, all of the proper information. My first question is, can you still assure me that States like Minnesota will receive prompt reimbursement; and, secondly, have other States that have submitted all of the proper forms already received their reimbursement?

Dr. MCCLELLAN. Yes, Congressman, I can reassure you. Many States have already done what I am pleased to hear what Governor Polenti in the State of Minnesota said. That is, submit information on the beneficiaries who need reimbursement and their claims information according to the system that we worked out with the States—with the States' own Medicaid collectors.

Many States are already very far along in that process. They sent us information on the beneficiaries for whom they want reimbursement. They sent through test files, told them make sure that the claims can be processed appropriately; and they are going to get paid according to the schedule that we set out. We are looking forward to getting the information from Minnesota. We haven't received that yet, but I do understand it is coming soon, and we will turn it around on schedule.

Mr. RAMSTAD. Thank you very much. It is gratifying to hear that. I know the Governor will be pleased as well as the taxpayers of Minnesota and senior citizens. I want to commend you for the way you responded to that problem. This is the way government should operate in working for people to respond to problems. You admitted the problem with the new eligibles, which was not surprising, given the enormity of the situation, the populations; and then you responded. You responded honestly, up front and promptly and took care of the problem; and I applaud you both for addressing that problem and solving it and making that reimbursement available. Thank you both. I yield back the balance of my time.

Mr. LEAVITT. Mr. Chairman, as previously indicated, this is a moment which, if it is all right, I will excuse myself and turn things over to Dr. Goodwrench. If that is inappropriate at this point, I would be willing to cancel my appointment, but if you would excuse me, I will take leave now.

Chairman THOMAS. [Presiding.] Mr. Secretary, if you would remain for just one moment, I believe the Acting Chair, the Gentlewoman from Connecticut, wants to make one small statement before I recognize the next Member on the list.

Mrs. JOHNSON OF CONNECTICUT. I just want to have it recognized in the record that we gave you explicit authority to use the CDC plan flexibly in the 2006 Labor-HHS bill (P.L. 109–149). Thank you.

Mr. LEAVITT. Madam Chairman, may I just express appreciation for that and also indicate that the airplane is owned by the

Centers for Disease Control and is on standby for public health purposes. It continues to be the primary use of that aircraft and will continue to be. It is an important asset for the Centers for Disease Control and as Congress explicitly then extended it to the use of the Secretary and the Director and will continue to use it only in appropriate circumstances and under ways that are consistent with the laws and the regulations of the United States. Thank you.

Chairman THOMAS. I want to thank you, Mr. Secretary. I apologize for being in one of the other two rings of the three-ring circus for a few moments, but, based upon the gentleman from New York's comments, I am pleased to know that this hearing has continued in a bipartisan manner, focusing on Medicare Part D and the concerns that we are facing in this oversight hearing, and the Chair is pleased to hear that. The gentleman from Michigan is recognized.

Mr. LEVIN. On that note, let me make clear we hold townhall meetings in our district, a number of them; and we had experts come to talk to seniors about how they might utilize this plan. It is also important, though, to get out the facts, and I just want to try to get to a few of them. In your testimony, Dr. McClellan, you say, as a result of this undertaking, an estimated 38.2 million beneficiaries have drug coverage as of June 11th, 2006. You say "as a result of this undertaking." How many of the 38.2 million people had drug coverage before this plan?

Dr. MCCLELLAN. Far fewer.

Mr. LEVIN. How many of the 38.2 had some prescription drug coverage? If you would just answer that question. Don't——

Dr. MCCLELLAN. I am trying to do the calculation in my head. It will take me a second to do the math. There are about 38 million beneficiaries who have coverage now; 11.6 million people signed up for coverage for the first time. That is 10 point——

Mr. LEVIN. If you subtract 11 from 38, you would say 27.

Dr. MCCLELLAN. Had some drug coverage.

Mr. LEVIN. I urge—when you say it is a result of this undertaking an estimated 38.2 million beneficiaries have drug coverage as of June 11th, of that 38 million, two-thirds had some prescription drug coverage before, which is why there is a reaction and effort to spend rather than look at the facts and get an understanding of them, and that is why we hold townhall meetings. That 38 million figure that is used and used, and used, doesn't really reflect what was there before; that is why I think we are saying, let people enroll, let them enroll beyond this deadline. In three words: Let them enroll. Some of them who are lower income can, but a number of them cannot. Secondly, I want to ask you about the nature of the enrollment. Do you have data on the plan level enrollment? Is that within your possession?

Dr. MCCLELLAN. We are developing a database on the recent enrollments. We had a big surge in enrollment in the last few weeks, and we are developing summary data on that which will be used to project cost.

Mr. LEVIN. Let me ask you point blank—and I am asking you this because we need the facts. We did not get them truthfully, I must say, or fully before this was voted on. You had data that was not given to us. The cost was kept in your files. Do you now have

the data on plan level enrollment? Do you have that available now? We talked about the doughnut hole, and millions are going to meet it. There is a lower cost than expected. In part, that means people are going to have less coverage. Do you have that data now?

Dr. MCCLELLAN. We have released data on the number of beneficiaries who have coverage or don't have coverage——

Mr. LEVIN. No. Do you have it on the nature of the coverage? Do you have the data on what plans people chose? Do you have that in your possession?

Dr. MCCLELLAN. We released information on our enrollment in the different health insurance plans and drug plans.

Mr. LEVIN. You have disclosed everything you have about what kinds of plans people chose.

Dr. MCCLELLAN. We will be happy to work with you and your staff on disclosing additional details of information. Once you get into finer and finer levels of data, we don't want to relate any beneficiaries' confidentiality.

Mr. LEVIN. We are not asking that.

Dr. MCCLELLAN. At a local level, we only have a limited level of beneficiaries enrolled in that, but that is a consideration.

Mr. LEVIN. I don't mean to interrupt you, but, look, you are kind of scooting around——

Dr. MCCLELLAN. I don't mean to.

Mr. LEVIN. Do you have—I am not asking you for the names of people. You say there are a few that were—so few chosen that—all right. I understand all of that. Do you have the data on the kinds of plans that people chose and the level of their coverage?

Dr. MCCLELLAN. I just showed you coverage on the——

Mr. LEVIN. The level of their coverage.

Dr. MCCLELLAN. The level.

Mr. LEVIN. We have been asking you for that data. When are you going to give it to us? Give us a date.

Dr. MCCLELLAN. I will work with—I will have my staff work with yours——

Mr. LEVIN. Give us a date.

Dr. MCCLELLAN. —exactly when you want and provide it. We have just released or we will release today State-level information on enrollment; and, as we have done in the past, we will bring that down further as soon as we can. If there is additional information you want, we will work with you.

Mr. LEVIN. We have asked for it, Mr. Chairman. I just want a specific answer. When will you give us?

Chairman THOMAS. I will tell the gentleman, one of the Chairs wanted to digest the information so we would have more today than we would have when people wanted to hold a hearing in which there would have been no data available. I have emphasized in my opening remarks that there will be additional hearings, if necessary; and the Chair joins with you in indicating that we want as much information as quickly as we can have it with an understanding of confidentiality protection for beneficiaries and proprietary protection for those who have driven the costs down significantly by virtue of the market-based plan of the Part D drug benefit.

Mr. LEVIN. I appreciate they are paying premiums. They must have the data. We have asked for it.

Chairman THOMAS. Having the data and presenting it takes a little time.

Mr. LEVIN. How much time?

Chairman THOMAS. I thought we gave a lot of time before we had this hearing. We will be pressing for additional information. One of the purposes of this hearing is to ask for information in the way Members want it. I don't expect them to anticipate any permutation of combination of data. They are hearing it from you. It will be structured in that way, with the due protection on confidentiality and proprietary rights, and we will get it as quickly as possible. The Chair will be on top of that, because I said I want facts, and if Members want to look at facts sliced in different ways, then they expect them to do it for us.

Dr. MCCLELLAN. We will be delighted to work——

Mr. LEVIN. We will have for you tomorrow, again, the data we want; and we would like a date by which you are going to provide it.

Dr. MCCLELLAN. Subject to the proprietary——

Chairman THOMAS. I will tell the gentleman that it would be wise for any Member who wishes specific information to submit the questions in writing so that they can be responsive to the particular concerns, and the Chair will make sure that they will be responsive in the minimum timeframe. To ask for a specific date, not knowing how many questions are going to be asked and how much data needs to be prepared in which particular way, may require us to prioritize the information that you are getting because it may not be able to provide it all. Any Member who wants to be first just needs to talk to me, and we will probably work it out.

Mr. STARK. I wrote on May 14, 2006 for some data. Would those be covered for a response? It was a detailed request.

Chairman THOMAS. Yes, but probably the smart thing to do would be——

Mr. STARK. Okay.

Chairman THOMAS. —provide it with the details that you want, with a special note that this is the second time you have——

Mr. STARK. Thank you.

Chairman THOMAS. Anyone who has a second request in gets to go ahead of those who have first requests. If there are third requests, let me know. Nothing but the facts. The gentleman from Texas wishes to inquire.

Mr. JOHNSON OF TEXAS. Thank you, Mr. Chairman. Good morning.

Dr. MCCLELLAN. Morning.

Mr. JOHNSON OF TEXAS. I appreciate what you all are doing. I wonder if you could tell me how many beneficiaries that have not signed up for coverage are likely to in the future, in your estimate. One, if we waive the penalty this year, do you have an idea of how many people would really benefit from that change; and, two, what potential harmful effects should we know about before considering waiving a penalty?

Dr. MCCLELLAN. Thank you.

Mr. JOHNSON OF TEXAS. Let me ask one other question. Do you have the authority to do it without Congress?

Dr. MCCLELLAN. We don't have the authority to waive the penalty for all beneficiaries without action by Congress. I think that is very clear. Because of the penalty and the enrollment deadline, we have a very high level of participation in the program now. In the last 2 weeks alone, more than 2 million people who were not low-income enrolled in the drug benefit. That was a huge surge, and it was because of the upcoming deadline. As a result of that, the cost of coverage for everyone is going to be lower.

The health status—the health risks of people in the program have improved considerably and that means lower premiums for everyone in Medicare. At this point, there are only a little bit over a million beneficiaries left who are not low-income and would be subject to that late enrollment penalty. That is about a third of the number of people who are subject to the Part D enrollment penalty which, as you know, has been very important for getting to high levels of participation and Medicare's physician insurance. Ninety-five percent of people now participate in that because of the penalty in part, and that keeps premiums down for everyone. People get the coverage even if they don't need it right away because they know they will be protected in the future if they have further illness that might drive up their health care cost.

We are not going to have a penalty for low-income beneficiaries, and I do think there are some more opportunities for those beneficiaries who enroll over the course of the year. We know from every previous government program and from our successes in enrollment to date that this is a very hard population to reach, but it can be done, and we are going to keep working to do that over the course of the year for people who aren't low-income. The vast majority have already signed up. The Congress designed this program to be a voluntary benefit. We didn't expect that every single person would do so. It is their choice. It is a voluntary program. The vast majority have, again, well over 80 percent. In overall numbers, enrollment now is at 90 percent.

Mr. JOHNSON OF TEXAS. I appreciate that. You know, I thank you for repeating that it is a voluntary program. Let me ask you one other question here. I understand CMS is consideration limbing the prescription drug programs (PDPs) in each region next year. Is that true, first of all; and, if so, do you have an idea of how that would affect the great competition that has brought prices down?

Dr. MCCLELLAN. Our first priority is making sure that we continue the successes of the program in giving people the benefits they prefer at a much lower cost than expected. I think the drug plans—all of us have learned a lot this year about what kind of choices people want, and competition itself is driving toward more simplicity in the drug benefit program. People clearly prefer plans with no deductible. They clearly prefer plans with flat co-pays. They had, in many cases, preferred plans that fill in the donut hole which are available nationwide. If we had put too many restrictions on plan choices early, we wouldn't have seen—people wouldn't have the opportunity to get the kind of coverage they want at a lower

cost. As we review the bids for 2007, we are doing to keep that experience in mind.

I do think there is more that we can do to help people compare plans effectively and quickly. We have learned more about how to do that, and we are going to do it, and we will be talking to the plans about making sure, given the fact that they now have a year of experience, are the choices they are offering really adding a new dimension. Are they important to have available for beneficiaries? We don't want to restrict those too much.

Mr. JOHNSON OF TEXAS. What you are telling me? You are not going to restrict PDPs.

Dr. MCCLELLAN. We do want to make sure the plans have learned from their experience this year in making available choices that really mean something for beneficiaries.

Mr. JOHNSON OF TEXAS. Thank you, sir. I yield back.

Chairman THOMAS. Gentleman yield briefly?

Mr. JOHNSON OF TEXAS. Yes, sir.

Chairman THOMAS. Part of the market concept is that people do learn based upon what happened in the marketplace; and those people who had very high-cost plans, we saw them drop. Certainly, people are looking at their product mix. They are going to make the changes. My concern is we should not have the actuaries who assume no change on the plans and no change on the beneficiaries are going to be any more accurate next year than they were this year. We have data. The market needs to work. The key to a market is to have the wherewithal, and we are concerned about that and the knowledge to make the choice. Partly this is about who didn't get the knowledge and who doesn't have the wherewithal, and I want to make sure that data focuses on those so that we can respond to those needs. The gentleman from Washington wishes to inquire.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I would say the market does not work. We have 46 million people in this country without health insurance at all. The insurance industry has been out there marketing the hell out of the people. I want to start by saying that most of us think this Medicare benefit was designed to help drug companies and insurance companies, not the beneficiaries. The most vulnerable group that we tried to help by passing this drug program are low-income seniors who do not have drug coverage. I think we all agree that that is the group most necessary to benefit out of this whole thing. All the other people who shifted around and did all of this other stuff are irrelevant to those people at the bottom who had nothing, and we said we are going to take care of them.

We now know that three-quarters of those people who were eligible for the low-income subsidy have not signed up. Most seniors still don't have the coverage, in spite of the fact that the President or the Secretary flew around in this CDC plane or whatever. They still don't have coverage. Now, I know what you are going to say, Dr. McClellan. You are going to say, well, it isn't a quarter who signed up. It is a third who signed up. That is not acceptable. That means two-thirds of the poorest have not gotten into this program. Families U.S.A. has done a study, and they will be on the next panel, of CMS data to show that only a quarter have signed up.

Now, CMS data is in itself a problem, because you keep redefining who is low-income and the asset tests and all this stuff. Is this an acceptable result for you, to have three-quarters of the lowest not covered?

Dr. MCCLELLAN. To review the numbers, about 13.2 million of our beneficiaries are eligible for the low-income subsidy. About 10 million of them have coverage now. There are 3.2 million who need to sign up on their own who we haven't reached yet. That is a large number, and that is why we are continuing some——

Mr. MCDERMOTT. They are 3 million at the bottom, Dr. McClellan.

Dr. MCCLELLAN. That is right. They are the hardest population to reach.

Mr. MCDERMOTT. If we had designed this program from the start so that we put in everybody who we knew was low-income and made the Medicare benefit for everybody on Medicare, rather than forcing people to go out and sign up, the 96-year-old people out there who are poor and don't have a son or a daughter to read all of the 14 brochures are never going to get into this program. You are counting on them not getting in so you can save some money.

Dr. MCCLELLAN. Absolutely not, Congressman. If you look at previous programs where benefits have just been added to Medicare, like the Medicaid dual-eligible coverage, I believe close to 40 percent of seniors who are eligible for that are not enrolled 40 years after that began. The supplemental low-income beneficiary program, the SLMBI program, less than half of the people who are eligible have enrolled.

Mr. MCDERMOTT. Because those programs were set up in the same way with the individual responsibility to go and find out about it.

Dr. MCCLELLAN. We are doing a heck of a lot better——

Mr. MCDERMOTT. They don't have that kind of access. You can put any of this stuff online. It isn't going to make a single bit of difference.

If we are going to tell stories about our experience, I hear people telling where they eat lunch and what they learn where they eat lunch. I went down into the cafeteria in this building, and one of the cashiers stopped me and said, could you help me figure out what plan I should get on. I said, well, what is the problem? She said, well, I have been looking at all of these plans and I can still buy a cheaper prescription if I just go to Costco than I can from any of these plans. I can't figure out what I am supposed to do, and my husband is 89 years old.

Now, if somebody working full time in this building is not able to figure it out, it is not because it is her fault. It is the design of this program which has been bad from the start and was designed by insurance companies to make sure they made money. I yield back the balance of my time.

Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Mr. Hayworth.

Mr. HAYWORTH. Thank you, Madam Chairwoman. You know, I am not a doctor and never played one on TV, but if I ventured a diagnosis, I think in several instances today we are seeing the

effects of a figurative ingestion on a massive scale of sour grapes. It is just amazing as one who takes a look at history. I was thinking about this the other day. Now, it is true that Medicare was signed into law when I was in the second grade, and certainly I would bow to those who have been on the planet longer. When a previous majority voted for the Medicare program that was signed into law, I don't—I cannot recall reading in the history books where a previous minority, who favored a program called Elder Care, then went to their constituents saying, oh, you don't want this, don't sign up, it is confusing, and it is bad for you; and then a few months later turn around and say people haven't signed up.

Now, we could argue from a political science perspective that one of the luxuries of being in the minority is being free to complain and complain, and complain, and, instantly change perspectives as to the nature of the complaint going from, in effect, saying don't sign up, don't sign up, don't sign up, to then saying why there hasn't been enough time to sign up, all while running——

Mr. POMEROY. Ask the gentleman to yield——

Mr. HAYWORTH. No, the gentleman will not yield. The gentleman will take his—regular order, Madam Chairman—I will take the time right now and then my friend from North Dakota can wax rhapsodic about the success story or perhaps, the lack thereof, at his at-large district that includes his entire State, where we have a few part-time residents in Arizona. The fact is this. Any program will have its challenges. As Dr. McClellan pointed out, Medicaid, which came around the same time as Medicare, still has a problem of 40 percent non-participation by those who arguably stand the most to gain.

Now, I just find it more than passing curious that the luxury of being able to have an instantaneous change of position often accompanied by another type of affliction, which seems to be instant amnesia, is very apparent along with that ingestion of sour grapes. The fact is this program is working; and, yes, I have had townhall meetings where I have had people come up and they say, Congressman, I am saving thousands of dollars here, real money. Perhaps the mission for all of us ought to be to focus on how we can make the program better with constructive criticism, even given the function of the calendar and the role of partisanship, which we understand in a free society, withstanding those temptations for perhaps just a nanosecond, to find a constructive way to make the program better.

Indeed, my friend from Washington State bemoans the fact that apparently there are industries—and most, I understand, indeed all industries operate on the premise of a profit, and somehow it is cast as if that is evil. No, that helps sustain businesses. Perhaps, if we want to rush heading in to massive deficits of what the minority proposed, if memory serves, in the motion to recommit more—close to a trillion dollar program of centralized Federal control that seemed to be based on Orwellian public health skills. If that is the way we want to help America, that certainly is another vision of the future. If you can offer that in a constructive manner, well, God bless you. We will have that debate, and the American people will decide. I will tell you no program is perfect, but I have been gratified to see the people who have stepped forward who took

the time to understand, who came from across the socioeconomic spectrum and who found benefits in the program. That doesn't mean there aren't challenges, and we look forward to see how we can improve.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Weller.

Mr. WELLER. Thank you, Madam Chair, and, Mr. McClellan, welcome to our Committee. Let me just begin by thanking you and your staff for the assistance you gave my staff and a lot of volunteers, and they loved the congressional district of Illinois during the sign-up period. I particularly want to commend Doug O'Brien of Illinois who we coordinated with, did yeoman's work; and I also want to thank a lot of the volunteers of our local senior service agencies who did incredible work helping thousands of seniors in my district: Marge Sahesic, with the county senior services; Connie Buchannan, with the Bridge Senior Center in Ottawa; and special thanks to Loretto Goeg and my own Patty Coloman, who works in my office in Joliet, who has personally helped thousands of seniors.

I mentioned Loretto Goeg as a great example of professional staff work at the senior service agency in Kankakee. I, like many of my colleagues, held a number of sign-up fairs. We did three rounds of sign-up opportunities for seniors throughout the district that I represent, and one was advertised in Channahan the last 2 hours. Loretto Goeg stuck around for 6 hours signing up an additional 150 seniors who wanted to sign up for the opportunity to lower their prescription drug costs.

Again, there are a lot of unsung heroes out there who really deserve a lot of the credit for helping bring this program from inception to actually helping seniors. A question actually to ask is, who really benefits? Seniors in my district, once they learned they could really save money, it wasn't that difficult to sign up, made a mad rush; and like many of my colleagues, we saw a big surge in sign-up toward the end of the sign-up period.

Ilene Eisel of Morris, Illinois,my hometown, stopped me 1 day; and she said, I have seen real savings from this prescription drug plan. In January through March of 2005, my prescription drug costs were $380 with the prescription drugs that I take every day. In the same period of time January through March of 2006, after she had signed up, after the program was in effect for her, her prescription drug costs were $115 for the same 3-month period. She saw almost a two-thirds savings. Mia Mary, who is in her eighties, saw similar savings. She said she saw about a two-thirds savings, and my own parents saw much lower monthly premiums than originally projected. The seniors who made the decision to sign up are seeing real savings in the district that I represent. I am pleased about that.

Administrator, you mentioned the figure—that 38.7 million seniors have either signed up for this benefit or had prescription drug benefits from other sources, and that is a record number of seniors having prescription drug coverage. There are 4 million eligible—Medicare-eligible seniors who have not signed up, who still have that opportunity; and we have seen figures saying that three-fourths of them are low-income seniors who have been able to get prescription drug benefit coverage for little or no cost, serving no

premiums under the program that we worked with the legislation and this Congress to provide.

I am interested in knowing what efforts you are taking to identify and find these seniors. You gave an extra 6 months for them to sign up, if they are low-income, penalty free; and I am interested in knowing what your steps are. We recently read in one of the major national newspapers about the Social Security legislation doing a mailing to half a million seniors over the age of 79 and older, who they believe did not sign up, who they want to encourage to do so. Can you tell us what is your plan to identify and find these seniors who fell through the cracks, for lack of a better term, who have not yet signed up? What are you doing and what are the initiatives you have in place?

Dr. MCCLELLAN. This is our high priority, because this is the vast majority of people who are not enrolled in coverage, as you said. They can get the drug coverage for zero premiums or very close to it, comprehensive benefits that will pay more than 95 percent of their drug cost. You mentioned the work that Social Security is doing with us. They are going to do another round of targeted mailings on what they have learned so far about people who have already enrolled in the benefit. We are also working with many other government agencies with the Legislation on Aging to continue local outreach events and also many private organizations.

You will hear on the second panel from Jim Firman of the National Counsel on Aging, which is a coalition of aging groups that are working with us on targeted outreach where—sharing information based on their lists of who have enrolled, what information we have on who has enrolled, so that we can target individualized, personalized outreach at the grassroots level. That has been very effective so far in getting people enrolled. We are going to be doing a lot more of it. We are working with NAACP——

Mrs. JOHNSON OF CONNECTICUT. Thank you.

Dr. MCCLELLAN. We will be in touch continuing the grassroots.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. Mr. Lewis.

Mr. LEWIS OF GEORGIA. Thank you very much. I wanted to tell him that many Members on this side of—the great majority of Members on this side of the aisle had townhall meetings. We never told people not to sign up. We had town hall meetings and forms to inform people what Medicare Part D was all about. Dr. McClellan, let me ask you. It has come to my attention that Medicare Part D may not be meeting the needs—the high-needs and high-risk patients. For example, the new heart failure drug Bydel—it is my understanding the FDA for the first time approved this drug in particular to treat heart failure in African Americans. It has reduced death and hospitalization from heart failure; and it saves lives, saves dollars. You know, as a person of medicine, that in African American communities people suffer from heart failure at a much greater rate than the majority of the population.

I was shocked to learn that most Part D plans failed to cover the drug. Only 25 percent of Part D plans covered the drug. This could easily be seen as discrimination based on race, failure to cover heart failure patients who are disproportionately African American

and to treat—as said before, we have seen a dramatic extension of life because of this drug in African Americans of heart failure. Can you tell me why Bydel is not available to patients under Part D?

Dr. MCCLELLAN. I have looked into this issue personally because, as you said, the problem of heart failures are much more prevalent in the African American community. We are never going to be able to address health disparities unless we not only bring our benefits up to date with drug coverage but help people use it effectively. I have worked with the National Medical Association and National Minority Health Months Foundation. Many other groups have come together to increase awareness about the availability of this important treatment and to make sure that we have access to cover for it.

I think the figures you have are out of date. There are a larger number of plans that are providing coverage for Bydel now, and we are working to make sure the generic drugs that make up Bydel are available as well. I would like to follow up with your staff to give you some up-to-date information on the Bydel coverage and the further steps we are taking to make sure that this, like other effective medicines, are available to the people who need it in Part D.

Mr. LEWIS OF GEORGIA. Mr. Director, I think those numbers are the numbers that was made available by your office to our staff.

Dr. MCCLELLAN. Again, we have been working very hard to make sure Bydel is covered and widely available for people who need it. I would like to follow up with your staff.

Mr. LEWIS OF GEORGIA. Thank you very much. Madam Chair, I would like to yield the balance of my time to Mr. Doggett.

Mr. DOGGETT. Thank you. Dr. McClellan, we have been hearing from community pharmacists from all over the country—they are the people from the frontlines who have to deal with the anger and confusion of seniors who are having problems with this Medicare prescription drug program—that they are often not being paid a dispensing fee big enough to even cover the little plastic vial labeling that goes out, that they receive messages that—not that the check is in the mail but that someday the check may be in the mail and long periods of delay in getting reimbursement when they provide prescription drugs. Is it your position that CMS cannot do anything to encourage prompt payment to community pharmacists and payment levels that cover their costs?

Dr. MCCLELLAN. Let me tell you about a couple of things that we have done. First of all, the pharmacists have been terrific in the implementation in benefit; and that is one reason that three million prescriptions a day are being filled under the Part D program for people with Medicare. It is a huge benefit to——

Mr. DOGGETT. My question is prompt payment. Is your position you cannot do anything to assure a prompt payment?

Dr. MCCLELLAN. Number one, we have reviewed contract terms that the plans have in place; and with just a few exceptions all of those terms are designed to get payments done within 30 days, which is at or below the industry standard. Number two——

Mr. DOGGETT. Is it your position that you could not affect the contract terms one way or the other?

Dr. MCCLELLAN. Absolutely. We affect them because we enforce strong pharmacy network requirements. If a pharmacist isn't being paid according to terms that they find acceptable and they don't choose to participate in a plan, if that happens on a widespread basis——

Mr. DOGGETT. If the pharmacist is not getting paid within 30 days, do they have a remedy?

Dr. MCCLELLAN. If they are not being paid according to their contract terms which have paying within 30 days, they should let us know if they have a complaint. If you have any specific situations like that, we want to hear about that.

Mr. DOGGETT. If the contract doesn't set a specific time, can you do anything about it?

Dr. MCCLELLAN. The contracts do.

Mr. DOGGETT. If it only provides vague language, since these are largely contracts of adhesion——

Dr. MCCLELLAN. That is not what we are seeing in the contracts used by all of the large Medicare prescription drug plans.

Mr. DOGGETT. If we have one, can we do anything about it? Is it your position that if the contract doesn't specify a specific time period, that you can not do anything about it under the terms of the——

Dr. MCCLELLAN. If it is not in the contract, we can't do anything about it. The vast majority of plans and the plans that are covering the vast majority of our beneficiaries do have contracts.

Mr. DOGGETT. What about setting the level of the dispensing fee?

Dr. MCCLELLAN. That has something that is set in the contracts as well.

Mr. DOGGETT. You do not have any impact on that, even if it doesn't cover the cost of dispensing?

Dr. MCCLELLAN. Again, if a pharmacy chooses not to participate in the program, if that happens on a widespread basis, which would be the case if the contract terms are too tight, then that plan will not meet our standard for being in the program.

Mr. DOGGETT. Do you have data on how many pharmacists have declined to participate in such programs?

Dr. MCCLELLAN. We have specific data on the pharmacy networks used by each plan because they have to meet all our pharmacy access standards and that is convenient neighborhood access all across their service area.

Mr. DOGGETT. Thank you very much.

Mrs. JOHNSON OF CONNECTICUT. Mr. Foley.

Mr. FOLEY. Thank you very much. Just to make a few comments on the program itself. I represent the fifth largest Medicare-eligible district in America. My neighbor has the third. Robert Wexler, my neighbor to the north, has the first.

This is very important to our seniors. Now, the statement has been made that no one suggested seniors not enroll. There was an effort, press conferences, by theDimensions in Critical Care Nursing (DCCN) candidates to come to nursing homes in my community and basically castigate this plan from start to finish as a bad plan, a confusing plan, a slap to the pharmaceutical companies—on ad nauseam. They suggested the seniors couldn't figure this out; and

these are the seniors that got us through the Depression, through World War II, through Korea, through Vietnam. Somehow they couldn't figure it out.

Let me first thank the Council on Aging for their incredible work on helping seniors—I saw it firsthand, seniors helping seniors—AARP for standing up in the breach, saying do not listen to this notion that you should not enroll. Please enroll—very, very important.

It was mentioned that a cashier thought it was cheaper to buy at Costco—and Costco is a phenomenal company that started with a few members by the fact that they were able to expand to a lot of—number of members were able to buy in bulk and pass the savings on to the consumer. That is exactly what this Medicare drug plan does. It aggregates seniors and allows the multitude of plans to choose how they will be able to save seniors money.

Now the irony, too, is the fact that in my hometown with the fifth largest Medicare-eligible seniors, each would say to me, please don't take away my ability to buy at CVS, Walgreens, Publix—and I should mention everyone so I don't feel like I slighted a company. They love their pharmacist. They love the local hometown feel, or they may have wanted to dial a 1–800 to America Medco, one of the other good providers. The message was loud and clear. They had a choice. They didn't want savings, and they see this program as working. I was stopped by many people saying thank you. I wasn't certain that was going to be a response unsolicited. People say I don't live in your district, but I want to thank you guys for working on this plan. First and foremost, I think if you put this in contract to a new plan, 38 million people enrolling within a year is a phenomenal success in one's imagination. The Florida lottery didn't have that many subscribers in the first 5 years of operation, and that is a chance game.

In context, the legislation deserves a lot of credit. Concerns echoed by some of my colleagues on both sides of the aisle need to be explored. The irony is we are listening. We are trying to make modifications. We extended enrollment periods for the low-income eligible. I don't think anyone at your agency has denied that there were bumps in the road, but we are working through them. Seniors are smarter than they have been given credit for. When those hearings took place in nursing homes, I was somewhat appalled that these people would be told don't do it. It is really confusing. You won't understand and you may be gypped. Well, they are now saving money.

On another topic, I wanted to talk to you about a very, very urgent crisis, and that is the Intravenous Immune Globulin (IVIG) lifesaving treatment for patients with primary immune deficiency diseases. We have contacted you, Mr. McCrery, Mr. Shaw, Mrs. Johnson, all asking HHS, CMS, and Food and Drug Administration (FDA) to develop an administrative response to this crisis. What is troubling is we haven't heard anything back from anyone. If you could or if some of your staff, please, this is something that is urgent. Our local hospitals are saying they cannot afford to continue treatment. They are no longer going to provide it.

That is something outside of Medicare Part D that I absolutely need the agency to see if they can determine why the supply crisis,

the pricing pressures on this particular opportunity—if you have a second to respond to that and then possibly just my notion on the Medicare Part D which I described as a very strong success at the point——

Dr. MCCLELLAN. On IVIG, we are going to be taking some further steps. We have looked at the pricing information, and we do expect to see some price increase in what Medicare pays coming soon. As you know, this is a problem that has got a lot of sources. It is a complex process of developing the IVIG molecules themselves, and the supply chains are fairly complex. There is a lot of resale going on. As a result, the Department of Health and Human Services is also going to be taking some steps to look more broadly at the development of IVIG supplies.

Overall, we have seen a huge increase in use of IVIG in the Medicare population in the last few years. That has created some challenges for supply, and it has also created some opportunities for us to take further steps to make sure we promote access to people who can really benefit from it. you will be hearing more from us on this very soon on both the pricing issues and on other steps that we think are very important to make sure that access problems in this complex supply chain are avoided.

On Part D, I couldn't agree with you more. When we give senior support and let them make choices, we see lots of bigger savings, much better benefits than ever before; and now we have got seniors who are much more involved with us in making decisions about their care and their coverage. It is going to help our health care system.

Mrs. JOHNSON OF CONNECTICUT. Mr. Becerra.

Mr. BECERRA. Thank you, Madam Chair. Dr. McClellan, thank you for being here. Let me see if I can get some clarity on the numbers here. I think, Mr. McDermott tried to make clear how many folks are now actually benefiting from Medicare Part D prescription drug coverage. I know that most of your publications talk about the 38 million people who are now receiving drug coverage, but, as you made clear with Mr. McDermott, most of those, more than two-thirds of those folks, already had drug coverage. You can't claim credit for folks who already had the coverage.

Of the folks who you say didn't have it and now applied, that is somewhere between 10 and 11 million. Once you look down at the fine print, you see 2 and 3 and perhaps even 4 million of those folks had coverage, and they were automatically enrolled in this plan, even though they could have had coverage through other means as well. Let's assume it is 10 to 11 million as you mentioned before. My understanding is you are estimating—Office of Management and Budget (OMB) is estimating costs for this Part D plan at about $71 billion for next year. If I do some quick math, that is about $7,000—approaching $7,000 for the 10 or 11 million people that you claim have now received prescription drug coverage.

On top of that $7,000 in taxpayer money that we are handing over to the pharmaceutical companies and to the HMOs in order to offer some kind of coverage, consumers, those seniors are still going to have to pay out of pocket about $3,600 before they can get a prescription drug without having to pay money out of pocket. My calculation—that is about $10,000—$10,600 that is coming out of

taxpayers' pockets, especially the Medicare recipient of this drug plan in order to get drugs which may cost far less than that. My question, I guess is, are you claiming mission accomplished?

Dr. MCCLELLAN. Well, Congressman, you have done a lot with numbers in the last minute. Let me focus on the——

Mr. BECERRA. Let me ask you a question. You can talk about the numbers as you see them. Are you claiming mission accomplished here?

Dr. MCCLELLAN. We are going after further enrollment among low-income beneficiaries——

Mr. BECERRA. Mission not yet——

Dr. MCCLELLAN. We are glad that 90 percent of people with Medicare have good secure coverage. That is close to 12 million that didn't have it at all before. Many millions more, including in your district who had Medicare Advantage plans with very limited benefits, are now going to have much more comprehensive——

Mr. BECERRA. You are still saying our mission is not yet accomplished.

Dr. MCCLELLAN. Especially the low-income beneficiaries who make up the——

Mr. BECERRA. Let me make sure. I know some folks are out there saying mission accomplished. We are done. We did a great job.

Dr. MCCLELLAN. People have done a great job to get us to this point, but there is a lot more to do to get even better health care.

Mr. BECERRA. There I agree with you. With regard to my district—I want to make sure it is clear, because I know the gentleman from Arizona tried to make sure that Democrats weren't trying to get out there to get people enrolled—I did a mailer to every senior household in my district where I explained to them the consequences of not applying by May 15th, where they could go. I listed a number of forums that I was doing in conjunction with senior centers and community health clinics, so that they could learn about the Medicare Part D program.

We did everything we could. Yet a lot of the folks that are in that 4 and a half million or so population that still has no coverage—and you will admit that about 4 and a half million people still have no coverage—they have still not understood the program. You have a whole bunch of folks in my district who still don't have coverage. Four and a half million people, even after all of this patting on the back——

Mr. LEWIS OF GEORGIA. Do they use a plane to get around L.A., Los Angeles?

Mr. BECERRA. My folks are lucky if they can get around in a bus. I would suspect that most government officials would be told they could do fine by these constituents, that they could do fine by commercial means as well. I hope Secretary Leavitt would take the message back that, unless he is going to tell us he needs to take a private jet to get around, that he should try to do what most Americans try to do to get around to visit with the people of the country.

My concern is we are paying a whole bunch of money for a plan where you still have several million people who have nothing and a whole lot of folks who are dual-eligibles, who qualify for—under

Medicaid prescription benefits, who are doing worse under this plan. I hope we continue to do more before anybody claims mission accomplished. The final question I would like to raise is, it still appears from everything I have seen, from all of the surveys and analyses, that the Veterans' Administration still gets a better price for the same prescription prices that are offered under Medicare Part D. Do you have any evidence to show that the Medicare Part D program beats the prices that the veterans legislation can negotiate for its veterans on prescription drugs?

Dr. MCCLELLAN. We have seen the cost of this coverage come down by more than 20 percent a year, but——

Mr. BECERRA. I know they came down, but can you beat the price that the VA gets for our veterans right now?

Dr. MCCLELLAN. The VA has four out of five prescriptions filled by mail order. They have very limited access to pharmacies. They have a narrower list of drugs covered than the Medicare programs do.

Mr. BECERRA. You are not telling me that senior veterans are healthier in most cases than regular veterans——

Dr. MCCLELLAN. What I will tell you a surprising number of people with VA coverage are now enrolled Medicare Part D. Close to 40 percent of people——

Mr. BECERRA. My question—I guess your answer is, no, you can't give me something that says that the prices under Medicare Part D are less than the prices you could get through the Veterans' Administration.

Dr. MCCLELLAN. If you gave me the authority to run a program where 80 percent of access to drugs is by mail order, where you can only get drugs through one pharmacy in a State. If you only have one——

Mr. BECERRA. Would you say we are shortchanging our veterans through our Veterans' Administration?

Mrs. JOHNSON OF CONNECTICUT. Mr. Becerra, would you please suspend a moment? You can't go back and forth like this. I was allowing the time for him to answer your questions. You can't keep adding, because he has to leave at 1:00. There are Members that haven't had one chance to ask questions. I am going to move on to Mr. Doggett, who has already had an opportunity to question, given the way you have used your time. Please, I am not trying to be rude. I am trying to enforce a uniformed discipline among the Committee.

Mr. DOGGETT. Excuse me. Wait a minute. Mr. Brady. I have to go back and forth here.

Mr. BRADY. Thank you, Madam Chairman. I think one of the reasons people believe Congress is so far out of touch is the focus we have. Today's hearing is a good example. Most of our seniors are trying to figure out how they can afford their medicines, and this plan helps them. We are focused on what types of planes our administrators fly around the country to educate them. Our focus needs to be on what kind of help are they getting, what kind of things can we do to improve their plan.

It seems clear in the 5-month—6-month enrollment period we have many of our seniors who have chosen to sign up for this plan. In other cases, we have helped those who had coverage in the past,

because we stopped the slide of plans that were being dropped fully. Half of our insurance for health insurance for seniors has been dropped over the last decade. We leveled that out, which is great news. We are helping offset some of the costs for like our Texas teachers and our State employees, help them with their costs. There are a lot of people who are benefiting from this plan in a fairly short period. Not that there is not room for improvement.

It seems, too, that not only in this first year, not only are seniors paying less for this plan than we had originally anticipated, but taxpayers are paying less for that plan as well than originally anticipated. That is all good news. Here is a point that Mr. Becerra brought up about the costs of medicines. It appears that this competition has driven down the costs of those drugs as well. In other words, we are not just helping seniors afford it when they go to the pharmacy, but we are actually driving the costs of those drugs down as a result of this competition. Can you talk a little bit about where we are at on those—and my understanding, the top 25 drugs seniors use are now down by about a third from what we can buy at a retail pharmacy, even more so by mail orders. Do you see that trend continuing or, as seniors move to different drugs, more competition in those specific areas?

Dr. MCCLELLAN. Seniors typically are saving over 50 percent on their drug costs through the plan, and a large part of that is because of the aggressive price negotiation that is going on. You will hear more from the second panel about that. The average price discount seems to be running 25 percent or more, even as much as 40 percent below as seniors were paying before.

We talked about Costco. Costco is participating in some of these programs to help drive much lower prices as well. That is much greater savings than has been anticipated through price discounts. We are tracking these prices over time. The only increases we are generally seeing are those that are in line with medical inflation. That applies to the VA program and other government programs as well. In addition to all of this aggressive price negotiation, we are also seeing seniors make informed choices about the drugs that they use. Typically, for seniors in this country, about half of the prescriptions filled are generic drugs. In many of the drug plans, as people have been able to find out how they can save even more when a generic version of their drug is available, they are switching over.

The drug plans have excellent coverage for this, discounts of 90—80 to 90 percent or more of what people have been paying—and many more of them are using generic drugs. Seniors who use generics and lower-cost drugs that work in the same ways of the drugs they are taking now won't save just 50 percent. They will save 70 to 80 percent on their drug cost. That is happening. Aggressive price negotiations, seniors getting involved in decisions about their care, us providing the help that they need so they can find out how to save, it is adding up to billions of dollars in savings for seniors and billions more than expected for savings for taxpayers.

Mr. BRADY. I will be one person who—I think the VA does a good job, but I think the choice is in the Medicare plan. VA doesn't

even cover some important drugs like Lipitor, which is widely used in our district. The amount of drugs and how people can get them are limited. We don't have that in the Medicare plans. Seniors have far more choices there. I just think it never makes sense to me why Medicare would pay $25,000 if you had a heart attack, but they wouldn't pay $80 a month to help you take Lipitor to prevent it in the first place. It seems like, in the end, seniors are going to spend more time with their grandkids and out of hospitals as a result of this Medicare plan.

We have still got a lot of work to do, but the initial data you bring us today, I think, is very encouraging. I yield back the balance of my time.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. Mr. Doggett.

Mr. DOGGETT. Thank you. Dr. McClellan, you have testified concerning the waiver of the May 15, 2006 deadline which shows who are low-income seniors. Is that a permanent extension without any enrollment penalties for being late?

Dr. MCCLELLAN. It is an extension through 2006, and it would be a permanent extension of late enrollment payment after 2006 so long as people enroll this year.

Mr. DOGGETT. As you know, the Social Security commissioner currently has access to income tax return information under the prescription drug law to determine which Medicare beneficiaries should pay increased Medicare part B premiums subject to privacy limitations. As I understand it, Social Security, under the low-income program, has, of course, the Social Security data. It has access to veterans' data. It has access to Federal employee retiree data. Do you believe that it would be helpful, subject to privacy limitations, to have access to income information so that you would know if some senior who was only getting $9 or $10,000 a year in Social Security had a stash of bonds or dividends and a lot of interest income to disqualify them?

Dr. MCCLELLAN. I think that would be an interesting issue to look into, and I am very much in the spirit of this hearing to find ways to improve the program. That does raise some privacy and data change issues, and I believe that the way that the data will be used for the income-related premium in 2007 is a little bit different than how it would need to be used to provide help here, but we would be happy——

Mr. DOGGETT. If you had all of that information, you could essentially, automatically enroll all of these low-income seniors or, at least, presumptively enroll them, couldn't you?

Dr. MCCLELLAN. Well, we would still need some confirmation about the income levels, such as you can't use this information alone to determine what someone's part B income-related premium——

Mr. DOGGETT. I appreciate your willingness to look at other ideas. As you know, on May the 25th, the 146 of us Members of Congress expressed concerns to you about this program. As I look over your testimony today, on page 11, if you focus, as we should, on those seniors who had to go and sign up—not somebody signing them up automatically, but if you look at the universe of seniors who had to sign up on their own, you have almost twice as many

low-income seniors who you have not signed up for extra help as you have signed up.

According to page 1 of the testimony, we are about to hear from the National Council on Aging, to whom you have outsourced much of the job of reaching these folks, there are apparently more than another million that are in part D, but they are not getting extra help. Now, today, we have heard repeatedly whether it was from Chairman Thomas or any of the other cheerleaders on this Committee, of the extraordinary accomplishments that you have had, and that the only thing wrong here is that some people have an attitude problem, you know; Democrats just have a bad attitude, and the problem that this Administration seems to have no matter what the issue, that not enough people watch Fox News, and the bad media and the media is reporting the facts.

If I look at your numbers today, you have, as of this morning, for the people who had to sign up on their own, failed to sign up, 71 percent of the low-income seniors in the extra help program. If we used the numbers that are probably more accurate from Families USA, you failed to sign up 75 percent of the seniors who qualify for extra help. At the Health Subcommittee, I suggest that a record like that, where three out of the four of the people that needed to sign up this year haven't done it, deserves a grade of about an F minus. Now, you may not agree with that grading approach, but I think pretty clearly the Administration doesn't get an A or a B, or a C, or even a D, and that in terms of the actual number of low-income seniors, and when Chairwoman Johnson and Chairman Thomas were extolling the virtues of this plan in the middle of the night when it was approved, they were telling us those were just the folks that didn't have coverage that were the near poor just above the dual-eligibles who really needed it the most. Yet, three out of four of them at this late date still have not been signed up. That appears to me whatever grade you put on it to be a pretty sorry job.

As far as the asset test itself—and one further question to you, as I understand the way that works, if we have a senior with $9 or $10,000 in Social Security income, pretty low-income, and over their lifetime, they have managed to scrimp and save almost as much as a Member of Congress earns in a month, about $12,000, and they are living with their kids, they are ineligible for low-income assistance and extra help. Shouldn't that kind of situation, doesn't that suggest that the asset test is too restrictive and that if we are going to talk about expanding the universe; we should be expanding the population of what are really poor seniors who are not, who are being disqualified from this program?

Dr. MCCLELLAN. Our first priority is reaching the seniors that have the least means, and as you pointed out, there are 3 million more that we still need to reach in addition to the ones who have signed up on their own, and who are continuing to sign up every day because of the outreach activities that we are undertaking hopefully together. We have also facilitated the enrollment of millions more. As you pointed out that the more we can facilitate enrollment, the more people get into the program. We are running way ahead of any historic programs, historically that programs targeted the same population have reached. I am very proud of that,

that we are improving and setting an unprecedented record for the number of low-income beneficiaries enrolled so far. We have a lot more to do——

Mr. DOGGETT. It has been worse than other programs?

Dr. MCCLELLAN. Absolutely, Medicaid dual eligible status has about 40 percent non participation rate after 40 years, many of the State prescription assistance programs took years to get to the level of participation that we have now, and we are also enrolling people in these other programs when we find them for Part D. Those are all new steps and better progress than has ever been seen before for reaching these kinds of populations. We need to keep it up. We are not done and we need to keep it up and we are going to work harder building on the efforts that have worked so far.

Mr. DOGGETT. I am going to take the chairwoman up on submitting additional specific questions about your testimony, and I hope you can give us a prompt answer.

Dr. MCCLELLAN. We look forward to working with you on that.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Doggett. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Madam Chair. Thank you, Dr. McClellan, for being here. Thank you for coming to my district in the State of Colorado as well.

You and Secretary Leavitt have been lauded a bit for the monumental effort that you two individually put forward, but you certainly had a great staff as well out my way, your regional director, Alex Trujillo, was absolutely amazing, and I would be remiss if I didn't mention him and the staffs that assisted him and their competence.

It strikes me and this program, the rollout of it may not quite be perfect, but it was a heroic undertaking, and think there is much, much good that we can point to, granted the challenges still lay in front of you. Given what I think to be fair, would be a very well organized effort to make sure that people didn't sign up, that they were confused, that they were disincentedfrom participating, and I think it is rather remarkable that you have accomplished in a very short period of time what you have accomplished.

I specifically called my district staff yesterday back in Colorado to ask them what kind of questions are you getting, what frustration level is there, what confusion still exists, how many people are calling, and what kind of questions are they calling about? My staff admitted that early on, I think no surprise to you or any of us that there was confusion, there were a lot of questions that perhaps at CMS the regional offices as well as back here that the response wasn't as efficient or as organized as it might have been, but that my staff tells me that that rapidly improved and at this point, the calls that she does get, which are very, very few, are calls of thanks. I mean that very sincerely, and we all know what our offices, we don't have partisan offices. Oftentimes, in fact, we get the calls from the other side that are specifically calling us. I think that the fact that essentially we are getting no news is very good news and I wanted to pass that on.

Dr. MCCLELLAN. Thank you.

Mr. BEAUPREZ. Let me ask, though, what have we learned to date? The confusion that existed, frankly, if I can use an analogy, when I go to the grocery store looking for breakfast cereal, I get confused. There is almost too many choices to pick from. Is that some of the challenge that is in front of us now that we have thrown so many choices out there now we are letting the marketplace, seniors, pick and choose and decide what works and what doesn't work? Are we going to see some consolidations of plans and offerings to seniors? Is that perhaps some of what we are going to see now as this evolves moo the next year or two?

Dr. MCCLELLAN. Let me talk about a couple of lessons related to your questions. One is, we learn we need to do invest a lot in helping our beneficiaries making choices. There were many beneficiaries who were daunted or confused in the beginning. We found that through 1–800 Medicare through local outreach efforts like through your office, through our regional office, through literally thousands of partners throughout the country, we can help people answer their questions and go from an hour or less from being confused and not knowing what to do and having heard about that all this in the media and thinking this may not be a good deal to be being competently enrolled in a drug plan and saving 50 percent or more of drug cost.

We stepped up our support of our 1–800 Medicare number. We invested more resources in that. When the big surge came on May 15th, we handled it, more than 600,000 calls in 1 day, more than 2 million people started their coverage on June 1st with no increase in complaint rates or problems or anything like that. by supporting our beneficiaries, by building this grass-roots network and backing it up with good personalized help, we enabled seniors to save far more money than expected and get better coverage than expected.

I think the second thing we have learned through this process is that competition really does work, and the more we can support people in making informed choices, the better this program is going to turn out. Most people have chosen plans other than the standard benefit. That is driving simplification in the future, there have been a limited number of plans at a low cost that offer certain kinds of benefits that have proven to be very popular with seniors and that will make it easier for people to make choices down the road as well. we are not going to leave them alone. We are going to provide even more support for making informed decisions, because that is the way to keep coverage up to date and that is the way to keep costs down.

Mr. BEAUPREZ. Final observation. I am hard pressed to think of another example when the government rolled out a program and it actually cost taxpayers less and beneficiaries less than we originally projected so my compliments. I yield back.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Pomeroy.

Mr. POMEROY. Madam Chair, let's just begin on this cost issue. Costs less. I voted for this program, and I understood at the time I voted for it, only Democrat on the Committee to vote for it, if I recall, I thought the cost was $400 billion over the 10-year projected life. I understand now that figure is well over $700 billion. Indeed at the time we voted for it, there was information prepared

by the Medicare actuary that was suppressed by the administration showing it well in excess of half a trillion dollars. This business of costs less, I haven't seen anything that says it is going to cost less. It is costing almost double. I don't know what they are talking about. It gets to the point of frustration I have with this whole debate.

Let me acknowledge maybe some filling on the Democrat side. I think that, Dr. McClellan, you have work your heart out to make this program work. I think we have given you a tough assignment because the program is the most complicated, certainly the most complicated Medicare benefit ever attempted, and the administration of it, extraordinarily complicated, and I think you worked very hard, in the Denver office was referenced earlier, I certainly could echo that comment too because we saw that effort in North Dakota.

I don't want any confusion from our side that we think there has been a failing of effort on your part to make it work. I think you have work very, very hard. I just think the program has got some real design problems. Here is where I get to the frustration on the other side. That everything having is perfect. You know we can't fix something until we come to reasonable grips to where the problems are. That is why a debate like today where one side says it is horrible, one side says it is perfect, we never can get down to business trying to identify things in a reasonable way. Perhaps, part of it is some of the discussion from some of the other side to me just doesn't square with the facts.

We had one Member on this Committee, not today, but said his office hadn't had a single call of confusion of problem. Our office has been inundated with calls. I don't know what, if he don't have a published number in the phone book or what but I can't imagine his office not getting a single call. We had another Member, we had two Members on the other side suggest that there have been efforts by the Democrats to keep people from enrolling. They haven't provided one fact and I challenge them to provide facts about their assertions. I take bitter offense to it because I have worked hard to make sure that people knew this program and could sign up.

I am going to introduce into the record the mailing that I prepared for seniors in terms of how to take some of the misery out of this business and how to sign up. I personally had seven townhall meetings with seniors. I hired additional staff and they conducted an additional 23 meetings independently and in conjunction with others trying to facilitate sign up. I had two round tables in addition to all of this with stakeholders to try to identify the problems.

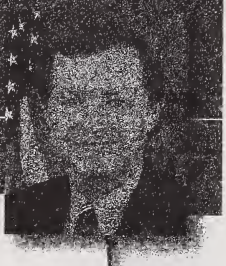
We worked very hard on our side to make this plan work. The problem is there is some problems in the plan. I think the complexity of it is totally misunderstood by a Member that suggested in today's hearing that he had a staff member that stayed 6 hours later and signed up 150 people. If my math is right, she is signing up one person in 2½ minutes. We couldn't even get the computer to boot up in 2½ minutes. I don't think there is an understanding on majority side about the complexity that we are dealing with here. In addition to my frustration, Dr. McClellan, about this costing more than I had thought, I am now frustrated that it was has achieved less than I thought it would. Not for the people that have

the coverage; my mother was able to save $2,000 out of a $4,000 bill, but your figures about us being 90 percent covered, don't square at all with the coverage, the rates we see in North Dakota.

We see, for all of the efforts made, we have had voluntary sign-ups, slightly less than 50 percent, if you add in addition to that, those with creditable coverage, we got about 72 percent covered, that was as of May 6, 2006. We have asked repeatedly for State specific data, have not gotten it. I will acknowledge that between May 6, 2006 and May 15, 2006 this number came up some but it certainly didn't come up to 90 percent. Now, the additional sign up efforts that you are making, I am glad that you are making additional efforts to sign up low-income payers, but, I think, they are far short of what the problem is. In North Dakota, we see that we are going to get 1,200 mailings to this low-income group. Dr. McClellan, our numbers of low-income seniors that will not have signed up will number many times that. I think it is going to be important for us—I will wrap up, Madam Chair.

We need the State's specific data so we can really see how far we have to go, and I look forward to trying to work with in a more bipartisan spirit, being clear-eyed about the problems and fixing them. Again, I salute you for the tremendous effort you personally have made to try to make this work.

[The mailer for the record follows:]



CONGRESSMAN EARL POMEROY

UNRAVELING THE MYSTERY OF THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT

January 2006

Dear Friend:

Beginning January 1, 2006, everyone with Medicare, regardless of income, health status, or prescription drug usage, will have access to prescription drug coverage.

The Medicare prescription drug program is more complicated than it needs to be and I'm working to improve it. However, it is important that seniors seriously evaluate their Medicare prescription drug coverage options because of its potential to help significantly in covering the costs of prescription drugs for many North Dakotans.

To help simplify the enrollment process, I am including a step by step approach to find a plan that is right for you or your family member. Seniors can also get more information by contacting the Medicare program directly at 1-800-MEDICARE (1-800-633-4227) or by visiting http://www.Medicare.gov.

I am committed to making this program simpler in the future, but enrolling now can save you money. I encourage you to look carefully at this benefit. Prescription drugs are expensive and this new Medicare benefit offers important help to seniors to alleviate that burden.

Please feel free to contact me with your thoughts on how we might improve Medicare's new prescription drug coverage program.

Sincerely,

Earl Pomeroy

Earl Pomeroy

NEWS FROM CONGRESSMAN EARL POMEROY

UNRAVELING THE MYSTERY OF THE NEW MEDICARE PRESCRIPTION DRUG BENEFIT

A Step by Step Approach to Prescription Drug Savings

1. Take Advantage of "Extra Help": Extra assistance is available for people with limited incomes. You may qualify for this assistance if your 2005 income was less than $14,355 for an individual or $19,245 for couples. The Social Security Administration can help you determine if you qualify for this assistance. Call them at 1-800-772-1213.

2. Determine Your Current Prescription Drug Coverage: Your decision to get Medicare prescription drug coverage depends on how you pay for your drugs now and how you get your Medicare coverage. For those without drug coverage, the new Medicare prescription drug benefit can offer significant savings. However, people with good retiree or union health plan drug coverage will probably choose to continue with their current health plan rather than sign up for the Medicare prescription drug benefit.

3. Collect Information About Your Current Drug Needs and Costs: List all your current medications and how much you pay for them. Different benefit plans offer coverage for different prescriptions, so it is important that you have information on which medications you take and their cost.

4. Contact Medicare to Search for the Right Plan for You: In order to help you pick a plan, Medicare can provide you a comparison of plans available that meet your needs. Just call Medicare, who is offering telephone assistance 24 hours a day, 7 days a week at 1-800-MEDICARE (1-800-633-4227). You also can visit Medicare's website at www.medicare.gov to compare prescription drug plans.

5. Contact Your Local Pharmacy to See Which Prescription Drug Plans They Honor: Your local pharmacy should have a list of drug plans they honor.

6. Analyze the Plans to Determine Which One Best Fits Your Needs: Now that you have narrowed down your options based on the drugs you use and your preferred pharmacist, it is time to pick a plan that meets your needs. Don't hesitate to ask your friends and family to help pick the plan that is right for you.

7. Enroll in a Plan: You can enroll with Medicare by phone at 1-800-MEDICARE (1-800-633-4227), on the Internet at www.medicare.gov or by contacting the plan of your choice.

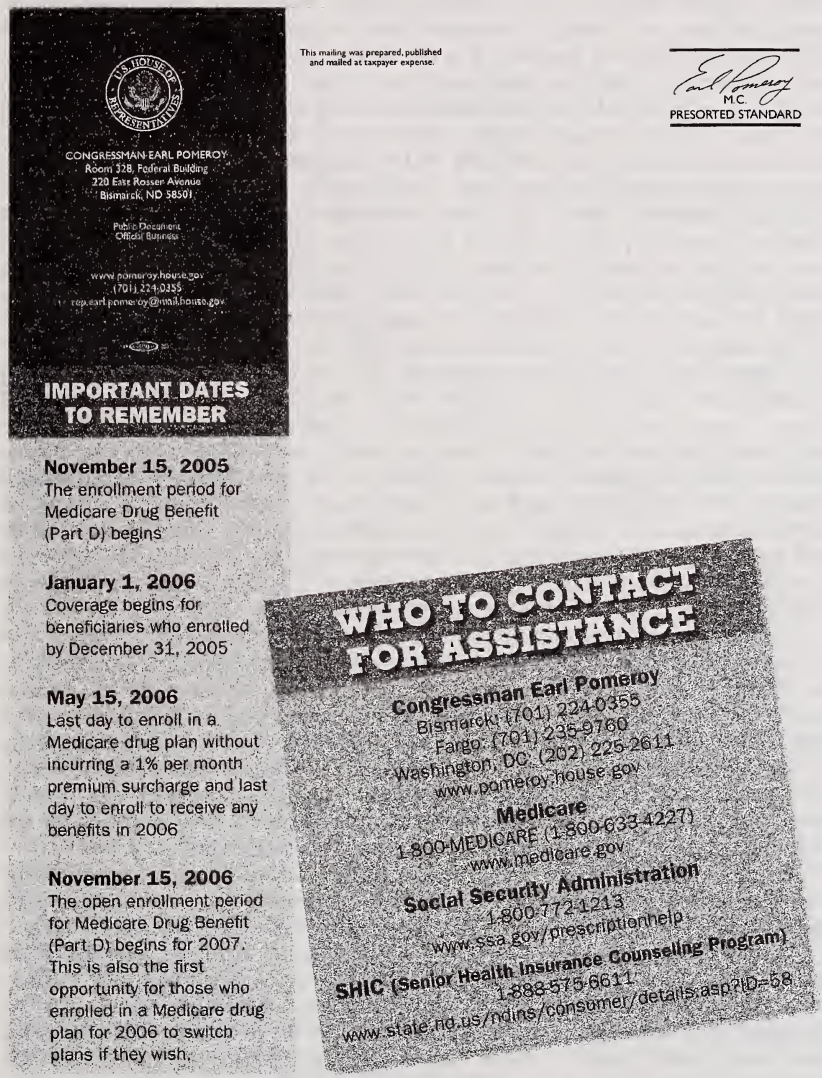
Consider Enrolling With Your Family and Friends

When my [illegible]-year-old mother and I recently sat down to figure out the Medicare prescription drug benefit, we were overwhelmed by [illegible]. But after taking advantage of Medicare's enrollment tools and making a few phone calls, she was able to narrow down her options and pick a plan that she liked.

We started by filling out Medicare's Personal Information Worksheet, which summarized my mother's current prescription drug needs and costs and entered this information into Medicare's online Plan Finder. We then contacted her local pharmacist to see which plans they would honor. Following these steps narrowed down her options to a manageable number. Then we sat down together, evaluated her options and enrolled her in a plan that will save her over $1,[illegible] a year.

For every senior the factors in determining which Medicare prescription drug plan is right for them are determined by their own personal preferences. In my mother's circumstance, she chose a plan accepted by her pharmacist, and compared her options based on the annual savings they would produce for her. We also decided to use the Internet to make our decisions but others may prefer to call Medicare at 1-800-MEDICARE (1-800-633-4227) and have them provide you a comparison of your options.

My mother and I enjoyed sitting down together as she made this important decision. I hope others will undertake this as a family project or enlist the help of trusted friends. We found it to be worth the effort, and the savings in drug costs meaningful.



Mrs. JOHNSON OF CONNECTICUT. Dr. McClellan, if you can keep it short, I know you have to leave and we have a couple for questions.

Dr. MCCLELLAN. Thank you for your assistance in getting people enrolled. As you know, as an insurance expert, more people use drug coverage over time, and there are more seniors in the program over time when you look at a comparable period 2006 and 2015, the costs have come down significantly from those earlier estimates, and we would be happy to go over those numbers with your staff. Thank you for your efforts on working with us on outreach for low-income beneficiaries.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Ms. Hart.

Ms. HART. Thank you, Madam Chair. First, I would like to respond to the gentleman's request that we give him some examples of his colleagues on the other side of the aisle discouraging people from signing up for the program, and I am not sure if Dr. McClellan was watching the Public Broadcasting Station (PBS), I think it was the Lehrer News Hour, the day I was—when I saw Mr. DeFazio from Oregon, basically being followed around by the news crew suggesting that this is a horrible program, and people shouldn't sign up for it. If I am correct, our staff has cited for us a letter June 19, 2003 signed by all the Ways and Means Democrats saying we won't go along with allowing the promise of a drug benefit that becomes a Trojan horse that ends Medicare as we know it. The bill is a bad deal for American senior citizens.

That seems pretty discouraging. We know the fact now. Even The New York Times has reported that this program is providing a significant benefit to people who couldn't afford prescription drugs. I am from a State that actually had a program for prescription drugs for seniors, but it was income based. The significant proportion of my population was unable to access prescription drugs through that program, and so, if they didn't have enough money to have insurance or didn't have a retirement plan that provided it and their income was just a little too high for what our program is called, the Pharmaceutical Assistance Contract for the Elderly (PACE), then they were up a creek and we didn't like that.

I supported this program to provide an opportunity to have the seniors in my State who didn't qualify for a very good program that the State provided, have healthier seniors so there can be access to the drugs they need for high blood pressure or whatever else they need. Doctor, I want to thank you for your cooperation with our delegation as we were working to implement this program this year, helping a lot of the pharmacists get the payment and get a lot of people a lot of the information available. I know it is a huge program as this is, it has actually been implemented very well.

I have a question for you, specifically, about Pennsylvania and about how maybe your office and our congressional delegation can help us to better coordinate the program with the PACE Program in Pennsylvania, because we have a significant funding stream that now doesn't have to be spent through the pace program but unfortunately we have been told initially that the law needs to be changed in Pennsylvania before we can move forward with gaining that additional benefit, and maybe filling in the donut holes for Pennsylvanians who are on the PACE Program. Do you have any thoughts or suggestions of ways we can get that done because our legislature and our Governor have been quite remiss in getting that done.

Dr. MCCLELLAN. It is important to do, Pennsylvania stands to save hundreds of millions of dollars a year for the State. That is money that could go back to taxpayers money that could go to improve the PACE Program and add more to the drug coverage available to seniors. It is a lot of money. The State has been developing a proposal with us for how to do the wraparound. Under State laws, I understand that the premiums can't be paid for additional beneficiaries under Part D for people who are in PACE in Part D, and that would be an important step. That is going to take legisla-

tion, and I hope that the legislature will act and the Governor will help make sure that happens soon.

Ms. HART. Okay. Well, that is not what I wanted to hear, because obviously, my Governor doesn't want to get this done because if he does, then the Republican House and Senate will get credit for it and he don't want them to win while he is running for reelection, and we are all bogged down in politics in Pennsylvania.

Dr. MCCLELLAN. It does mean hundreds of dollars in savings, as you pointed out, and as the delegation has pointed out, if the State would act, they could salve a lot of money for the program and get better drug coverage for the seniors in Pennsylvania.

Ms. HART. We are going to work to try to get them to move on this, because clearly, Pennsylvania was already an attractive State for seniors. My district's significant senior population is just an example of the many seniors who have remained there and have lived there all their lives because the benefit had been good as well, they weren't forced to seek shelter elsewhere.

As we move forward on this, one of the my colleagues had asked the question about the Department making some decisions about offering fewer plans as we learn which types of plans are more in demand. I heard part of the answer to that. Is that going to also incorporate several different selections for each category? In other words, I wouldn't want us to have one sort of low-income plan, one plan that will help somebody who may have a higher requirement for more obscure prescriptions, those kind of things. Are we going to still getting competition within those sort of categories?

Dr. MCCLELLAN. Absolutely. Let me reiterate that what we have seen through competition is that seniors are getting coverage that is much more like what they want, no deductibles, very predictable payments, specific co-payments for each drug and so forth. We are not going to change that. What we would like to do is take further steps to make it easier for beneficiaries to make these comparisons. We have learned a lot this year on how we can provide information to seniors to help them get the coverage that they want, that is the best way to keep driving forward with this competitive approach that is clearly leading to lower costs and better coverage.

Mrs. JOHNSON OF CONNECTICUT. Mrs. Tubbs Jones.

Mrs. TUBBS JONES. Thank you, Madam Chair, you know, it is very interesting that we are being castigated as having not supported getting our seniors signed up for the program. It is a misrepresentation of the truth. You can go down the line. I have my flyer I sent to my constituents. He has his flyer. All of us tried to sign up seniors. It is only because the program has at least extended to a number of seniors that the Republicans now want to say that we were trying not to get people to something signed up. It is a misrepresentation. It is a lie. I am pissed about them saying some stuff like that.

Let me go on to another subject. I have a June 6, 2006 letter from my one of my constituents that said last September I tried to get Medicare. I have insurance with my husband, but it wasn't enough. Every month I called to see if I put it on, every month they said it takes a while to get. I did, and in April I was denied because of it was too late, they said the application never got there.

When I applied again, they had found it so they said I would be put on but it would take months, my check didn't come and I inquired and she said they put me on finally, but they were holding my check for premiums from January. Now I would be penalized, just crazy.

The woman ended up not having her Social Security check, being told back and forth that she didn't have coverage. She didn't have coverage. If she didn't get the prescription drug benefit, then she could have signed up, and they took her money. We need to work on that issue because there are a lot of seniors whose checks they were taking money from them when they thought they had no coverage and couldn't buy any drugs. You can imagine they have a check for $150 and $200 that you need that money if that is all the money you have coming in. I am going to be talking fast because I don't have but 5 minutes. Another issue, along with the sign up and the problems with the checks, is to make sure that the computers are working to together so that seniors are not being confused or messed up in the process.

Let's talk about health care and the best of health care. We are saying now that we can use drugs to treat people so that they won't end up in the hospital later on. There is an issue that I have been presented with regard to vaccines and whether vaccines are being covered by Medicare if they, in fact, are being covered by the Medicare prescription drug, the doctor is not being paid, that that was not being paid. Please look into what is happening with vaccines.

Let's talk about disparity in health, and I have some real concerns that have been presented to me—and my papers are confused here—with regard to—if I put my glasses on, I might be able to see it. Oh. I am convinced that African American seniors have an opportunity to take Bydel, however you pronounce it, which addresses the issue of heart failure. When at the beginning, when there was a whole discussion about privatizing Social Security, the discussion was African Americans die early so we ought to fix our Social Security, not fix why they die early.

Now apparently, we have a drug that may fix that, but there is a question about whether or not it is covered under Part D. Please take a look at that, otherwise we are looking at the disparity in health care as we deal with senior citizens, African American seniors. I want to applaud the work that you've done. I don't want you to sit on your laurels because if you sit on your laurels, then we really haven't done—millions of seniors out there who need help with the coverage who still haven't got covered. I want to ask you, like I have been asking you for the past 6 months. Waive the penalty. Waive the penalty. Waive the penalty. Why should we penalize people if it is costing you less? Anyway, we ought to give these seniors, who have been confused, having problems, the opportunity to sign up.

You can answer any of those questions you would but most important I need you to make sure that you stay on the problem with these seniors losing their money and the confusion in their checks and their sign up.

Dr. MCCLELLAN. I am looking forward to continuing to work with you on all of these issues. On the issue of Bydel, we talked about that a little earlier with Congressman Lewis, and we have

done a lot of work to make sure that people who need that drug will get access to it. I can follow up with your staff on that issue.

Mrs. TUBBS JONES. Would you please?

Dr. MCCLELLAN. For beneficiaries who are withholding premiums from their Social Security checks that is working well for 4.4 million of our beneficiaries.

Mrs. TUBBS JONES. Can I send you many that I hear from?

Dr. MCCLELLAN. You should. That is what I wanted to get to next. By our analysis, about 78,000 who have not yet fully sorted out the premium withholding or who need to have some corrections made.

Mrs. TUBBS JONES. Stop there. Tell me about vaccines real quick.

Dr. MCCLELLAN. For vaccines, new vaccines are covered under Part D. We have required the plans to provide them in a way that does not require difficulties in access through, for difficulties in physicians getting paid, there is a new vaccine coming on the market now where we will be expecting the plan to provide coverage for it. It is a vaccine for shingles.

Mrs. TUBBS JONES. It what is the appeals process for the denial?

Dr. MCCLELLAN. There is an appeal process in place for any drug that is covered in the program. So far, we have had about 3,000 appeals go through our system. The vast majority of those have been handled on time. About half of those end up getting found in favor of the patient and we will——

Mrs. TUBBS JONES. Vaccines are included in that appeal?

Dr. MCCLELLAN. If there is a coverage issue related to a vaccine, we will deal with that as well.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Dr. McClellan. The gentlelady has raised a lot of interesting questions. Mr. Thompson.

Mr. THOMPSON. Thank you, Madam Chair. I too want to note that I think it is inappropriate behavior for Committee Members, Members of this Committee, to make suggests or not suggestions, but statements that Members of our side of the aisle went out and tried to discourage people from signing up. I have got one of the brochures just like everyone else, Madam Chair. I would like it put in the record. I am one who not only had townhall meetings, but I did media events to let people know the deadline was coming up. I put together in every one of my counties a provider working group to try and figure out how to get the word out, how to make sure we minimize the problems that everybody recognizes and knew that we were going to face in signing these people up.

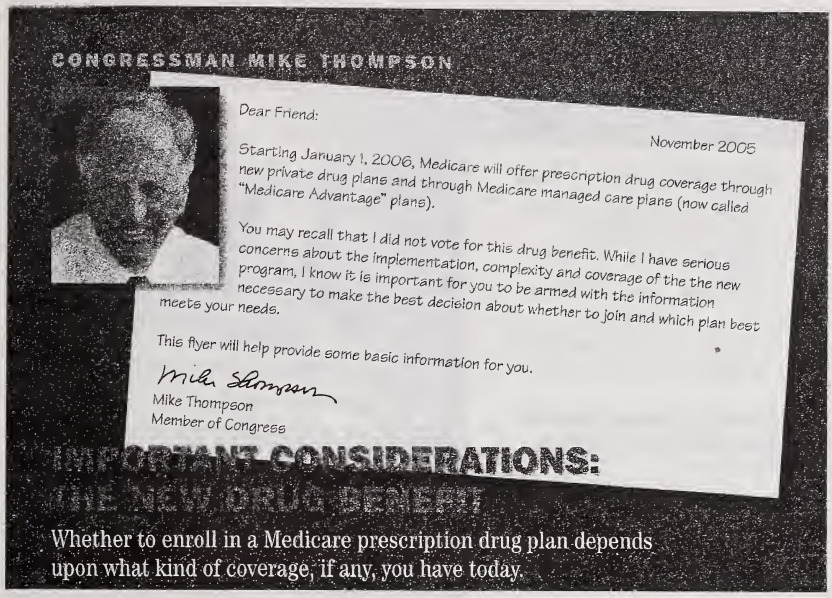
To sit here and suggest that Democrats tried to discourage people from signing up is somewhere between intellectual dishonesty and political nonsense, and Madam Chairman, I don't think it should be allowed in this Committee. We are here to focus on how to make these program better and how we can make sure that the seniors that we all represent get the prescription drugs that they need. Dr. McClellan, I want to also thank you for the hard work that you have done. I will recognize your successes. I am one who believes strongly that there are also other areas where we need to

make improvements, and that is the sort of thing that we could be focusing on.

Someone earlier talked about poor people who had no kids to help them get signed up. I want to recognize a program that helps fill that gap, and you know those are the ship programs. They do a remarkable job. As a matter of fact you, yourself, have recognized these folks as your partners. CMS staff have recognized them as being some of the best trained people in the field in helping people sign up. Yet, notwithstanding that recognition, in this budget, their funding has been cut. They are already under-funded going in and now they are going to see a drop in funding. I know in California, we had an increase of about 20 times the daily phone calls throughout California in helping people sign up for the prescription drug program. In the smallest county in my district, Elanour County, which was a little less than 1 percent of my entire district that I represent, we went from 200 calls a month to 200 calls a day.

These folks are the frontline. They are helping these other folks sign up. We need to provide them with the funding that they need to fulfill this duty. I would like to know how it is you go about setting the funding levels and why in the world would we even consider decreasing their funding.

[The mailer for the record follows:]



If you have prescription drug coverage through a retiree plan:
Check with your former employer about your options before doing anything. You may not need to do anything.

CAUTION: If you drop your employer or union health coverage, you may not be able to rejoin it later.

If you are on Medi-Cal and Medicare:
Your Medi-Cal drug coverage will end on December 31, 2005 and your new Medicare-based coverage will begin on January 1, 2006. Information is now available on options in our area; you should choose the plan that best suits your needs.

CAUTION: To receive free premiums, you will need to pick a plan with average or below average premiums. If you fail to choose a plan, you will be automatically assigned to a plan. You will be able to change plans monthly if need be.

If you are enrolled in a Medicare Managed Care plan (such as Kaiser, etc.):
Your plan will send you information about your options. If you want to stay with your current plan and it offers a prescription drug plan, you may enroll.

If you don't want to remain in that plan, you may enroll in a different Medicare Managed Care plan or return to Medicare and select a prescription drug plan.

If you currently do not have prescription drug coverage:
Investigate your options, but remember monthly premiums will be higher if you do not enroll by May 15, 2006. You will also want to determine if you are eligible for limited income assistance.

CAUTION: If you are receiving telemarketing calls from participatingdrug plans:

Don't give out any personal information – including your Medicare number – unless you are certain you are speaking to a certified plan representative. If you want to stop receiving these and all other telemarketing calls, visit www.donotcall.gov and sign up for the federal Do Not Call list.

Dr. MCCLELLAN. I agree with you fully about the importance of the ship programs in helping us reach beneficiaries at the grassroots level. Since I came into this job a couple of years ago, we had more than a 250 percent increase in the ship funding because they are such important partners and we intend to continue that high legal of funding going forward.

Mr. THOMPSON. If I could interrupt you for a second, before the cut that they are going to experience, they were getting about 70 cents per benefactor, so they were woefully under-funded before we started this program. We don't need to be reducing them anymore.

Dr. MCCLELLAN. We want to continue the high level support that we have provided in the last couple of years and take other

steps, make it easier for them to do their jobs. We have supported volunteer networks to help them increase the level of staff they provide. As you see, they are very efficient because they use a lot of volunteers and a lot of neighbors who can help other people in their communities at a low cost. We are also providing a lot of backup help around May 15th, for a number of ships that had an overload of calls they shifted them to us, we did those callbacks.

Mr. THOMPSON. My time is going to run out so—The other thing I want to talk to you about is this noninterference clause that you cite in regard to involvement in the pharmacies. My pharmacies are telling me, even ones not within my district, but throughout the State of California, that it is a function of not just getting their payments on time, but getting an adequate amount of payment to cover their costs of these drugs. I would like you to work on that and answer me in a letter, because my time is going to run out.

I want to just mention also the issue of privacy. One of the biggest providers had just two horrific privacy breaches. In light of what has happened over at the Veterans Administration, I think this is something we should be concerned about. I would like to know what you are going to prevent that. Are you doing anything, I guess it was Humana that had the problems. Are you doing anything to penalize them or to make sure that they don't have these security breaches again? You know privacy theft is something we are all concerned about. This is a problem that is just glaring.

Dr. MCCLELLAN. Any privacy breaches are unacceptable; we took immediate action when we learned of this case. It was around, I believe, 20,000 beneficiaries involved, the plan is require to provide them with free credit monitoring for a year. They have had to notify each beneficiary personally. They have had to put in place a corrective plan to make sure it doesn't happen again. If we see any recurrence like this, we can go further with civil monetary penalties and other steps. It is unacceptable to put beneficiaries' personal information in jeopardy.

Mr. FOLEY. [Presiding.] The time of the gentleman is expired. The gentleman from Illinois is recognized for 5 minutes.

Mr. EMANUEL. I would like to join my colleagues about the suggestion of one other colleague and remind him, although he is not present, the Chairman asked this not to be a political meeting for political grandstanding, and obviously the message was directed toward us, but not heard fully around the panel here. I have two issues, if I can. Dr. McClellan, the last time you appeared in Subcommittee, you got cut off based on our vote and your time, et cetera. We, at that point—you were talking about the virtues of competition and the private plans having reduced the price. I suggest to you that some of us who are in favor of direct negotiations, weren't looking for direct negotiations to supplement the competition between private plans, but a basic Medicare provided plan, and the competition whether you want to go WellPoint, Humana, et cetera, whatever, United, whatever plan you wanted to pick, and that that competition if you believed in the virtue and the principle of competition driving down prices that we would have that true competition, a Medicare-negotiated price for those who wanted to enter it, versus if you wanted to pick United, Humana, or any

other plan that is out there, private, and let the private sector and the public sector compete for membership, so you would have true competition and choice, and you were not able to finish at that point, so I am going to give you the opportunity to finish.

Dr. MCCLELLAN. First, I'm always happy to see any specific proposal you have if you have got legislative language or something like that, that Congressional Budget Office (CBO) could score, that we can really get an evaluation around about whether and how this would save money. I am delighted to do that. Since the time we last spoke, we have learned even more about how competition has driven down prices. The average premium that beneficiaries are paying this year is under $24 a month. That is almost 40 percent less than had been projected last year. As our actuaries have said and as our independent CBO analysts have said, they haven't seen a proposal on government negotiation——

Mr. EMANUEL. First of all, you and I need not have to go through this, but I am more than willing to go through it. What the Veterans Administration does on negotiations, what different private companies do on negotiations, as well as the fact that former Secretary Tommy Thompson said give me the power to negotiate, and I can use it. We have his own analysis of what he could do as a negotiator. I have full confidence that both Secretary Leavitt and yourself could do a very good job. It is a vote of confidence in you.

Lastly, if you look at in that sense of the competition that would exist, you would actually be setting up real competition. You wouldn't have any of the troubles you have had on the implementation side. None of that problem would have existed. We can, I will give you then studies after studies are done, both for the Veterans Administration and what has also been released by a number of other organizations that are out there. Again, we are trying to do here is get a lower price and better efficiency. We are leaving, in my view, a ton of money on the table.

Dr. MCCLELLAN. When we spoke last, I would ask you if you have a concrete proposal it could be scored by CBO or that would give us enough detail to see how this would really work——

Mr. EMANUEL. Maybe your memory is different from mine last time you said you didn't believe it could work. I am more than willing to present to you the plan and get that scored, and any problem that is not a problem, because I think what we are doing is setting up a false choice here between direct negotiations or private provided plans when we are asking for pure competition.

Second, as I know you are familiar with the MedPAC recommendations on savings. There is about $60 billion whether that is on the overpayment to Health Maintenance Organizations (HMO), it is slush fund, as noted, it is a slush fund, other areas that can come up to around $63 billion over a 10-year period of time, how to save money from the original Medicare bill and given every other investment we make, whether that in the area of education, other parts of health care, we are always looking at how to make them A, better, or B, unfortunately because of budget constraints, they are being cut. Have you done any analysis of taking on those recommendations, or what you would do?

Dr. MCCLELLAN. We have adopted many of the MedPAC recommendations for further savings in the program. In fact, on Medicare advantage, in particular, as you know we are phasing out the so-called budget neutrality adjustment. Congress came in behind our administrative proposal on that and reinforced it, so that is happening over the next several years. With the new competitive system in Medicare, some of the savings provided when we get lower bids from private health plans goes to the government——

Mr. EMANUEL. Overpayment.

Dr. MCCLELLAN. Those steps are addressing the so-called overpayments. I also urge you to keep in mind, Congressman, that in your district we have seen a large number of beneficiaries newly enrolled in Medicare advantage plans that are saving them on average $100 a month with much more comprehensive benefits and much better coverage for treatment for people with chronic illnesses, especially need because of the payment reform we have implemented. I don't think this is the time to be making seniors pay more for their health care, so I want to——

Mr. EMANUEL. They have analyzed it and they have identified $63 billion worth of savings, and we are overpaying in the area especially in the insurance part of this, I don't think we should, and I want to make sure that we are pursuing it. I am not suggesting we are going to raise——

Dr. MCCLELLAN. As long as we are not taking take away billions of dollars of savings for seniors, I am happy to work with you on pursuing some other——

Mr. EMANUEL. That will be the second letter on the $63 billion we will get an update on each of those. Thank you.

Mr. FOLEY. Time of the gentleman has expired. The gentleman from Louisiana is recognized for 5 minutes.

Mr. JEFFERSON. Thank you, Mr. Chairman. I want to ask a question about the prescription drug benefits and other Medicare-related questions that has to do with Katrina victims, people who have been displaced. First one is about the PDP program, where, as you know, if one is enrolled in a program automatically, if they haven't made a choice by a certain time. We had many people who have removed to Texas or some other place where they don't have the same PDP region as Louisiana, and there are some gaps in there. We are getting complaints now about gaps in coverage there.

I want to ask you to focus on that for a minute and try to give me a response to how you are dealing with it. Second of all, a lot of the folks displaced were African American seniors. part B doesn't apply to the Civil Rights Act of 1964, doesn't apply there. I really want to have your thoughts about how we might get after the issues of discrimination that are being reported to our office along those lines. Then moving away from prescription drug issues, we have the Medigap insurance issue is a big problem for us, because we have people who are not, who haven't paid the premium because of a lack of communication, displacement whatever, and they are lapses there. When the lapse occurs, of course, they lose the benefit.

That is another issue that we have to we are concerned about down our way. The fourth one, I suppose, is the one that deals with the beneficiaries in the Medicare advantage plans. Then we have

the same kinds of issue where in our area we had a huge enrollment in Medicare advantage plans. In the New Orleans parish, we had more than 20,000 people and more than any other area in the whole hurricane-affected area, and we have the same issues there about how people are fouled up with their plans or disconnected with their coverage and that sort of thing.

I want to know I heard you make a reference to when Mr. McCrery was inquiring about how you were going about making specific plans to take care of these issues and others that are affecting our evacuees from Louisiana or our citizens from our State who are, in some places, moving from one place to another having a hard time keeping up with the programs and calling the office saying they are losing an opportunity to have coverage. Could you please tell me how you are getting after that and what your plans are?

Dr. MCCLELLAN. Absolutely. Helping the victims of Hurricane Katrina has been one of our top priorities. I know we have been working with your staff as well as Congressman McCrery and others from the affected region to make sure we are dealing with cases as they arise. The complaints we are seeing and problems we are seeing have really diminished a lot, but they are still there and we are still paying close attention.

One of the things we are doing is extending the enrollment period for people who have been affected by Katrina for the rest of the year. I misspoke a little earlier when I said Katrina and Rita. This is really a program that applies to Katrina victims. They have until the end of the year to enroll in Medicare Part D without a penalty. There will be no late enrollment period for them. We have also extended the enrollment in Medicare part B, the physician insurance program as well.

For people who are enrolled in Medicare coverage and are in a prescription drug plan or a Medicare advantage plan that worked for them while they were in Orleans parish, but they have since moved to another area, they can have a special opportunity to switch plans as well to make sure that they are in a plan that works for them where they are. Then if they move back again, and they need to switch plans again, we will help them do that as well. There also are some national plans—for prescriptions——

Mr. JEFFERSON. How do they get information about how to get these choices?

Dr. MCCLELLAN. Calling us at 1–800 Medicare. We also are working through our regional offices with your district offices and many district offices of Members from the region, if they happen to call your office, we can provide some personalized assistance for them as well.

Mr. JEFFERSON. Are you getting a—are the efforts you are making now, are they meeting with success? We get a lot of complaints. Are you making progress guess in this area——

Dr. MCCLELLAN. We are making progress. Helping these individuals is a big challenge, as you know. They are in different places around the country. As we find out about them and where they are and what kind of help they need, we can assist them. that is why one of our big outreach efforts right now is focus number 1 on people with limited incomes who are still eligible for the program and

haven't enrolled and number 2, on people who are victims of Hurricane Katrina, who have been displaced, and, so, haven't had the same opportunity to take advantage of the new coverage. We will be doing a lot more outreach over the next 6 months. All of our enrollment efforts really focused on helping those two populations primarily.

Mr. JEFFERSON. Thank you very much.

Mr. FOLEY. Time of gentleman is expired. On behalf of Chairman Thomas and Ranking Member Rangel, we want to thank Secretary Leavitt and Dr. McClellan for their testimony today and for their insight. We ask, I ask unanimous consent that the Members have 5 legislative days to submit questions into the record. Hearing no objection, unanimous consent is agreed to. We will now turn to our second panel and ask those to come before us, Michael Starkowski, deputy commissioner Connecticut Department of Social Services, Hartford Connecticut; Mark Merritt, president and chief executive officer, Pharmaceutical Care Management Association; Ronald Pollack, executive director, Families USA; Karen Ignagni, president and chief executive officer of American Health Insurance Plans; James Firman, president, chief executive officer, National Council on Aging; Jorge Gomez, Chair, senior issues task force, National Association of Insurance Commissioners, Kansas City Missouri.

We will let our panelists and Members know and the audience that votes are expected at approximately 1:45. We will allow the opening statement and we will see as the clock approaches, how far we get and it will be the decision of the Chair to determine whether we recess subject to.

Mrs. JOHNSON OF CONNECTICUT. [Presiding.] Thank you very much. My intent is we will move through the opening statements. I am sorry you had to wait such a long time, but we should be able to hear everyone's opening statement and then we will see how many are going to be able to come back. It is unusual for us to get quite this far behind.

First of all, let me just welcome Mr. Starkowski of Connecticut. I am very glad you can be here. The efforts that you made to work to outreach were really exceptional. For Members who are here, the efforts that you and Governor Rell of Connecticut made to help the cities understand how this could help them alleviate the pressure on their budgets was really exceptional. We will just start through now, Mr. Starkowski.

STATEMENT OF MICHAEL STARKOWSKI, DEPUTY COMMISSIONER, CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Mr. STARKOWSKI. Thank you, Congresswoman Johnson. Good afternoon. I guess it is afternoon now. Good afternoon, Madam Chairman, Ranking Member Rangel, and distinguished Members of the Committee. Special hello to you, Congresswoman Johnson, you have worked tirelessly and effortlessly and shown great leadership on health care issues in the State of Connecticut. You have worked on resolving home care issues. You have worked on the Medicare Part D program. Now you are on the forefront of bringing the electronic medical records into our health care community. I would be remiss if I didn't recognize Congressman John Larson.

Congressman Larson is also an avid advocate for the seniors in the State of Connecticut. My name is Michael Starkowski. I am the deputy commissioner for the Department of Social Services in the State of Connecticut. In my capacity as Deputy Commissioner, I have responsibility for the Medicaid program, and relative to today's hearing, I have responsibility for the implementation and operation of the Medicare RX program in Connecticut. I appreciate the opportunity today to talk about Connecticut's experience with Medicare RX, and hope that my testimony will provide you with some insight on our experience. I will be pleased to answer any questions after I finish my testimony. I understand the Members of this Committee have received copies of my written testimony. I would like to take this time to mention some of the highlights in Connecticut's response to Medicare RX.

Overall, Connecticut stands to save approximately $80 million due to the implementation of Medicare RX. As a State with a history of providing a generous benefits structure, we reinvested significant portions of these savings back into the pharmaceutical services. We assumed financial responsibility for dual eligible copayments and premium differentials. We wrapped around our Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) program and assumed financial responsibility for the premiums and co-pay differentials for the ConnPACE members. We assumed financial responsibility for the nonformulary pharmaceuticals while clients navigate through the exception process and we will provide administrative assistance to help providers and clients navigate through the exception process. We committed funds to continue outreach education and what we call the drug regimen reviews.

These initiatives will complement the Medicare RX program and will ease the anxiety level of the beneficiaries in the State of Connecticut. Overall, the Connecticut response has been successful due to the can-do attitude of the staff, the ship volunteers and the stakeholders involved. We started early. We provided information to clients, providers and advocates. We invested in outreach and education. We maintained positive open communications with stakeholders including CMS officials. We implemented creative solutions such as the operation of a mobile service center, drug regimen reviews and payment for municipal actuarial services.

Our mobile service center with four private work stations and full computer access through a wireless satellite connections was in high demand and served as a lightning rod to attract seniors to Medicare events throughout the State. Our drug regimen review led to enrollment of dual eligible and ConnPACE beneficiaries to the most cost effective and appropriate plans. The State investment of less than $500,000 for actuarial services resulted in projected municipal revenue increases of up to $5 million. With cash strapped local governments struggling, this was well worth the investment.

Like other States, our Medicare RX experience has not been problem free, but unlike a number of States, Connecticut was prepared to respond. From the Connecticut perspective, we feel the implementation has been successful. We did this with the cooperation of and assistance from CMS leadership and involvement of all the

Connecticut stakeholders and the leadership of Governor Rell. On behalf of the State of Connecticut, I would like to thank the distinguished Members of this Committee for their diligent oversight of the Medicare RX program, and their continued interest on the issues the beneficiaries and States are facing.

In particular, I would like to acknowledge the work and participation of Connecticut's Congresswoman, Nancy Johnson. Congresswoman Johnson has been an advocate for health care solutions, especially for seniors. She has taken an active role in Connecticut with regard to the implementation of the Medicare RX program, and personally participated in numerous forums and enrollment activities. Congressman John Larson and his staff have also shown a keen interest in this program and partnership paid inside State forums. I would like to thank the Governor of the State of Connecticut and acknowledge that the Governor and the legislature in Connecticut have made this program better for the seniors in Connecticut and hopefully this program will continue to be a success in the State of Connecticut.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. It certainly has been a team effort and I remind you that any program requires good leadership at the State level and both you and the governor provided it. Thank you.

[The prepared statement of Mr. Starkowski follows:]

Statement of Michael Starkowski, Deputy Commissioner, Connecticut Department of Social Services, Hartford, CT

Starting January 1, 2006, Medicare offered a prescription drug option to over 40 million Medicare beneficiaries nationwide including over 530,000 CT beneficiaries. If Connecticut followed the statistical range of Medicare beneficiaries without ANY drug coverage in a twelve month period, we would estimate that we had over 110,000 beneficiaries without access to drug coverage. While this new benefit provides significant relief for these beneficiaries, it was also a significant shift for those clients who have traditionally received drug coverage through existing state or federal programs. The state of Connecticut, through the Department of Social Services, has made every effort to ease the transition to Medicare RX for the dual eligible clients (those with Medicaid and Medicare), the ConnPACE clients (our state pharmaceutical assistance program) and the general Medicare beneficiaries who lack drug coverage. Through an initiative generated by Governor M. Jodi Rell, we have also taken a proactive and supportive stance to insure that our municipalities take advantage of available Medicare reimbursement for retired employee drug coverage.

We feel these efforts have been successful in Connecticut because of our commitment to make this work for our seniors and people with disabilities. Our "can do" attitude and our willingness to work creatively and cooperatively with those individuals and entities on the ground floor—clients, their advocates, the 600+ pharmacies across the state, the prescribers and the drug plans—to work with those individuals and entities at the 20,000 foot level with policy and decision making authority, the Ct legislative body, our congressional delegation and of course leadership at CMS.

I would like to take this opportunity to describe our efforts and experiences as we navigated through the successes and growing pains of Medicare Rx.

CT has taken additional steps in order to make this program meet the needs of our beneficiaries. As a continuation of our commitment, the state has decided to cover the co pays for the dual eligibles, any premium differentials for dual eligibles and the premium and co pays which exceed the standard ConnPACE co pay of $16.25. In the most recent CT legislative session, dollars were also appropriated to fund situations where the prescribing physician feels the formulary drug is inappropriate and the PDP has either denied the request for the non-formulary drug or is in the process of reviewing the request for an exception.

Outreach Activities:

Starting in early 2005, while the state was still working under the first phase of Medicare Rx, the Transitional Assistance Prescription Drug Card, we began legislative and public information forums for providers, constituents and advocacy groups

providing the general information available on the upcoming program. These forums provided an opportunity for Connecticut's providers and beneficiaries to ask questions and identify issues regarding the future implementation of Medicare Rx.

Connecticut has had a rich history of providing assistance to our seniors and disabled individuals. These healthcare services not only included a state-funded pharmacy program, but state-funded home care initiatives and other initiatives such as subsidized assisted living. Governor Rell and members of the legislature were very concerned that the implementation of Medicare Rx could negatively impact the 50,000+ seniors and persons with disabilities who were Medicare beneficiaries that received pharmaceutical assistance through our ConnPACE Program. They were also concerned that our dual eligible population, those clients receiving Medicare and Medicaid services, would see their services diminish or their costs increase. It was important to meet with the Governor, her staff and legislative leaders early on and on a continuing basis, to discuss the framework of the program and the potential Connecticut specific solutions.

We knew from the beginning that the success of the program would be contingent on an understanding of the operations of the program by providers including prescribers and participating pharmacies. Without an understanding and without their cooperation and support, the implementation would be doomed for failure. Through our fiscal intermediary, Electronic Data Systems (EDS) we held six (6) statewide provider forums, again with the dual purpose—the state providing information and interpretation on the implementation, and the providers having the ability to ask procedural questions and identify potential issues. In addition to forums throughout the state we provided provider communications through hardcopy materials and updated web information on a regular basis. As we approached the fall of 2005, CMS and SSA representatives eagerly participated in a number of these provider forums. Understanding that all of our beneficiaries did not have the ability or capacity to live in a residential setting, we held specialized forums for providers of long-term care such as, skilled nursing home administrators, residential care home providers and assisted living administrators.

With the dedication of staff in my agency and primarily the staff in the CHOICES program, we partnered with various state agencies, legal assistance and advocacy groups. Our five area agencies on aging and a host of other entities from the Arthritis Foundation to the Connecticut Pharmacy Association to United Way assisted in spreading the word and providing assistance. Through today, our staff and trained volunteers have held over 1,500 events, which include booths and exhibits at fairs, group presentations, and on-site enrollment events. These activities were held at housing complexes, hospitals, houses of worship, nutrition sites, and centers throughout the state. Included in these events we provided one-one one counseling regarding plan selection, low-income subsidy application assistance and benefits comparisons to over 34,000 beneficiaries. These efforts continue on a regular basis with a more intensified effort at explaining the plan that enrollees have enrolled in and how to navigate the system.

To compliment our specialized efforts, we also developed avenues to provide information throughout the state through media access. On November 10, 2005 we held a live question and answer session in the form of a ?town hall meeting' which was broadcast through public television to the entire state during prime viewing hours. The segment was also re-broadcast and made available to local access stations, community centers and senior centers throughout the state. Dr. Charlotte Yeh, CMS Region 1 Regional Administrator participated in the forum along with a local Pharmacist, a Geriatrician and myself. The live audience was comprised of a wide range of stakeholders that included representatives of advocacy groups, local housing authorities, healthcare professionals, senior center administrators and Medicare beneficiaries. In addition to the live participatory audience, questions were received through the telephone and Internet. The show won high praises from the community and the seniors we serve.

Building on the success of the public television town hall meeting, public television joined with my Department and produced an ?info-mercial' where actors portraying beneficiaries walked through their options in a light-hearted dream sequence. The video explained the various options available to clients depending on their status as a dual eligible, ConnPACE recipient or general beneficiary. It was distributed to local access stations and cable operators throughout the state.

Electronic media was not limited to the town hall meeting and the video, but was also utilized through continuous TV and radio interviews. The use of local call-in shows and interviews brought the word to the beneficiaries, their caretakers and their families.

Connecticut established 1–800–994–9422 as a direct line to a bank of trained counselors throughout the state with United Way Info-Line-211 serving as after-

hour counselors for nights and weekends. Of course, we utilized tailored traditional brochures and card stuffers, which advertised our 1–800 number and the availability of counselors to work with individual beneficiaries on their specific problems. The stuffers and brochures were made available throughout the state at local pharmacies, supermarkets, doctor offices, hairdressers, and just about every place a beneficiary would come in contact with.

With this population, we also recognized that it was incumbent on us to literally bring the message to them. Through a combination of funding granted from CMS in the form of a state pharmacy assistance program grant and state dollars, we were able to obtain a Medicare Rx mobile office service center. We customized a 35-foot recreational vehicle and turned it into a full-service/handicapped accessible office with 4 private workstations and full computer access through wireless satellite connections. The Medicare Rx bus provided an opportunity for counselors to reach beneficiaries regardless of the capabilities at the shopping mall, community center or the senior center. When individuals entered the vehicle they could not only have private discussions concerning their best available option for a Medicare Part D plan based on their individual circumstance and drug regimen, clients could also be screened for other available services such as food stamps, energy assistance and meals-on-wheels. The vehicle also included portable wireless workstations, which could be brought into the senior center or housing complex, etc. to provide additional assistance on-site. From the beginning, the vehicle and services provided were in high-demand and served as a lightening rod to attract seniors to local Medicare Rx events throughout the state.

Auto-Enrollment:

With close to 50,000 Medicare beneficiaries receiving drug coverage through Connecticut's ConnPACE program, it was important for our state to ensure that eligible beneficiaries enroll in Medicare Rx. Connecticut law mandated that ConnPACE recipients, who were also Medicare eligible, enroll in Medicare Rx.

Enrollment of beneficiaries in Medicare Rx meant a savings of $29 million in State Fiscal Year 2007 in the 100% state-funded ConnPACE program. Understanding that the varied co pay levels and the monthly premiums could act as a deterrent for ConnPACE clients, Governor Rell and the legislature agreed to hold our ConnPACE clients harmless for any expenses over and above their annual ConnPACE enrollment fee of $30.00 and their standard co pay of $16.25. With this in mind, we obligated the state to pay any premium or premium differential for those clients whose drug regimen was more appropriately served by a plan not included in one of the 11 federal benchmark plans available in CT. While this premium cost reduced the original estimated savings to the state, by auto-enrolling clients in plans whose formularies accommodated the needs of the individual ConnPACE clients, the clients and the state saved on additional healthcare costs. Auto-enrollment authority was given to my department through state legislation and federal authority was granted for this activity by CMS. Auto-enrollment was implemented with an individual drug regimen review while preserving the client's opportunity and right to choose a plan. Auto-enrollment, contingent on the individual drug regimen review, was the key to alleviating the many concerns of beneficiaries enrolled in our ConnPACE program.

While CMS auto-enrolled our dual eligible population, over 65,000 beneficiaries, their auto-enrollment was based solely on a random assignment and not an intelligent selection process through an individualized drug regimen review. We understand that a random auto-enrollment for the dual eligible population has less severe implications since these clients have the continuing opportunity to switch plans on a monthly basis, but we feel the random auto-enrollment was one of the factors that led to confusion and problems at the pharmacy counter during the early stages of implementation.

Drug Regimen Review:

My Department partnered with the UCONN School of Pharmacy and the Connecticut Pharmacy Association to review the maintenance drug regimen of all ConnPACE recipients for the past six (6) months of claims history. In recognition of their efforts, the UConn students took second place in a national competition for Medicare outreach programs held by theNational Council of State Pharmacy Association Executives. Advanced pharmacy students were utilized to review those drug regimens where clients received up to seven maintenance drugs per month while we contracted with independent pharmacists to review clients with more intense needs, those with eight maintenance drugs or more per month. As pharmaceuticals have become such an important cog in the wheel of healthcare, it should be no surprise that some of our beneficiaries who are also on ConnPACE take up to 25 mainte-

nance drugs per month. The CMS State Pharmaceutical Assistance Program grant allowed us to provide stipends to the students for their efforts and reimbursement to the pharmacists for their services. On an individual basis, the identified maintenance drugs for each individual were entered into the CMS Plan Finder Tool to determine which plan covered all or the majority of all of their drugs within their zip code location. Recipients were provided a ten-day opportunity to select one of the three appropriate recommended plans or be auto-enrolled by the state in one of the three recommended plans.

As of today, all Medicare beneficiaries in ConnPACE have been enrolled in plans and the feedback from the clients on the plan auto-assignments has been positive overall. This is important because ConnPACE clients as general Medicare beneficiaries (other than those individuals we auto-enrolled) do not have an opportunity until November 15th to switch plans.

Although all dual eligibles were randomly auto-enrolled by CMS, the Department felt it was important to ensure these individuals were in the most appropriate plan to meet their drug needs. CMS' auto-enrollment was strictly ?random' without regards to the client's existing drug regimen. In order to provide intelligent selection, the Department provided a voucher to each dual eligible that was redeemable at their local pharmacy. These recipients were encouraged to take this voucher to their local pharmacy for assistance in verifying their existing drug regimen and assistance in selecting a plan best suited to their needs. While the plan selected by CMS may be identified as the best plan, taking this extra step ensured the client was in the most cost effective plan and allowed the recipient the opportunity to intelligently switch plans. Pharmacists used the CMS Plan Finder Tool in this process as well and were reimbursed a minimal fee for their services.

We feel that a drug regimen review is an important factor as a component of any auto-enrollment. It not only provides the most appropriate plan for the beneficiary with regard it their healthcare needs, it provides the most cost effective plan for the beneficiary and where the beneficiary is enrolled in a state-funded program it also maximizes the cost savings to state programs.

Municipal Assistance:

One of the key components of the Medicare Rx federal legislation provides a financial incentive for qualified employers, unions and municipalities that bear the financial burden of retiree drug coverage. The "28% Federal Subsidy" incentive, provides reimbursement from CMS for those entities that provide a benefit that is actuarially equivalent to or greater than the Medicare Rx benefit. While the amount of the financial incentive payment can vary dramatically from municipality to municipality depending on the coverage provided and the charges incurred, Governor Rell felt that all municipalities should be provided the wherewithal to have their expenditures reviewed, file the actuarial attestation and take advantage of the opportunity. In that vein, my department advised all municipal leaders of the program and the Governor's offer to bear the cost of the actuarial services. In June 2005, I sent out these letters explaining the benefit to municipalities and offering the services of our contracted actuary. While not all of the municipalities have taken advantage of the offer, to date the state's investment of under $500,000 for actuarial services is projected to generate from $4.5—$5 million for the participating municipalities.

Implementation:

Implementation of a sophisticated nation-wide program that involves two federal agencies (SSA and HHS), automated eligibility systems, multiple software programs and databases and hundreds of specialized options administered through individual prescription drug plans are difficult to implement to say the least. Even with months and months of preparation, experience will tell you that problems will occur. While communication, including conference calls were held with state officials as we moved closer to the implementation date, more systems testing across the various databases and stakeholders may have alleviated some of the implementation problems.

Technical problems plagued the program at its inception, which led to misidentification of dual eligible clients, misidentification of co pays or deductibles for dual eligible clients and the lack of appropriate confirmation of enrollment for dual eligible clients. In Connecticut, these problems may have also impacted those ConnPACE clients who had self-selected plans and enrolled in a Prescription Drug Plan (PDP) on their own. Due to these early problems, Connecticut made a conscious decision to significantly delay the auto-enrollment of ConnPACE clients until the glitches were rectified and we were satisfied that the situation would not negatively impact ConnPACE clients.

Governor Rell, in an effort to avoid a healthcare crisis for dual eligible or ConnPACE clients enrolled in Medicare RX, authorized my Department to suspend the system edits which would have limited state payments for these clients and directed us to allow pharmacists to bill the state where technical problems interfered with filling the prescriptions presented by these clients. Initially we implemented the changes for a 5-day period, allowing time for the specific problems to be identified and corrected. After a series of reviews and assessments of the situation, the suspension was extended for 20 additional days, then again through March. During this suspension period we worked closely with federal officials, the individual prescription drug plans, pharmacists, advocates and a host of other states facing the same issues. While federal officials were very receptive to identification of the problems, very sensitive to the impact on the clients and very thankful to the states for stepping in, the corrections took significantly longer than originally anticipated. In their efforts to rectify the problems, HHS/CMS, made top officials available for daily conference calls such as CMS Administrator Dr. McClellan and Deputy Administrator Leslie Norwalk. In addition, they had senior technicians working closely on the issues, they exponentially increased their customer service representatives, they reinforced the responsibilities of the PDPs and they established working committees of existing state Medicaid Directors to provide assistance and guidance. It is unfortunate that states had to institute stop-gap measures that in most situations remained in place through mid-March 2006. To monitor the progress of the system corrections my Department periodically sent a set of questions in the form of a survey to a representative sample of local pharmacies. Responses illustrated that incrementally the problems were being addressed. During our stop-gap measures, I and my staff also kept in close contact and held a series of meetings with Governor Rell and her staff, state legislators and advocacy groups. In addition to the state investment to fund the stopgap measures, the most critical piece during this period was open communications with all of the stakeholders. The eventual service to the clients was the ultimate gauge in the test of whether the system was working. Based on our continued open communications, we feel the system is operational and is meeting the objectives identified by Congress.

For informational purposes, I am providing some of the facts and expenditures through the stopgap period. We implemented our edit suspension on January 6, 2006 and continued the suspension through March 8, 2006. During this period, we processed over 245,000 claims for the auto-enrolled dual eligible clients and potentially those ConnPACE clients who self-enrolled. The price tag for these stopgap claim payments was approximately $17 million.

Based on a directive from CMS, we anticipate reimbursement for our dual eligible Part D attributable expenses from the PDPs through a claiming and reconciliation process overseen by CMS. As of today, my Department is in the process of providing claim details and eligibility files to CMS's designated contractor, PCG. In addition, Connecticut has filed for the CMS simplified Medicare waiver application process to obtain reimbursement for any differential not paid by the PDP's and reimbursement for state administrative expenditures related to this transition process. Based on guidance from CMS, we anticipate partial payment by the end of June 2006 with the balance, after reconciliation, due prior to September 2006. After PDP and CMS reimbursement of pharmaceutical claims, the state will have an unspecified amount of non-reimbursed dual eligible expenditures, which were for co pays and non-covered drugs.

As with other states we appreciated the level of attention that states received from the staff and executives at CMS during the stopgap period. Regular conference calls were held between various state and CMS officials, which included discussions of operational issues, recommended solutions and timetables for implementing the corrections. These conference calls and discussions continue as CMS honors their commitment to rectify the problems and ensure that the PDP's and their systems are operating in accordance with the program guidelines.

Early on states were concerned that the operation of multiple independent databases (SSA for low-income subsidy and CMS for Medicare eligibility/enrollment), state Medicaid information systems and Prescription Drug Plan enrollment systems could cause potential problems. While all entities continue to transfer data at varying time frames, the potential for conflicting data and ultimate consequence of conflicting data, have negative implications for states, for PDP's and for clients. In an effort to address part of the problem related to dual eligibles, CMS developed what is called an "E1" transaction that allows the pharmacist to dispense the medication to a dual eligible client, even if, as a new Medicare beneficiary, they are misidentified. The E1 transaction is in essence a ?holding tank' for claims to be resolved at a future date and is an example of CMS's willingness to address the problem in order to ensure that clients get their needed medications. Due to the neces-

sity to transfer data between and among multiple systems, it can take up to three weeks before a client receives confirmation in hand that they are enrolled in the PDP they selected. A glitch in any one of these system transfers extends the ability of the client to receive confirmation of their enrollment out even further.

Exception Process:

In recognition of potential situations where prescriptions are denied as non-formulary for dual eligible clients or ConnPACE clients, the state has appropriated funding to honor temporary supplies of the non-formulary drugs during the various stages of the exception process. The department is negotiating with an independent contractor to administer the exception filing process and monitor the participation by the prescribers and the PDPs. The contractor will receive pertinent information regarding the issuance of a temporary supply of a non-formulary drug and will contact the prescriber with the information. They will provide the prescriber with the opportunity to change to the formulary drug or if the prescriber chooses, provide the prescriber with the exception form for filing with the PDP. The filing of the exception form will be through the intermediary with the intermediary tracking the response from the PDP and subsequent filings. The state acknowledges the necessity of implementing formularies in the program and will use the services of the intermediary to ensure that all of the stakeholders are honoring their responsibilities in the process. In the event that we determine that particular providers are not living up to their obligations, the department will take appropriate action. In the event that we determine that particular PDPs are not living up to their obligations, we will advise CMS of their inappropriate activities.

Clawback:

We acknowledge the concept of ?clawback payments' may be controversial and questioned by some state authorities. Connecticut had serious issues related to the original trend lines used to estimate the states obligation for clawback payments, but those issues have since been addressed by the revised trend assumptions and clawback payment obligations provided to us. The change in the trend line and subsequent calculation as identified by CMS reduces the states clawback obligation by over $11 million for the first 12 month period. For the first year, the adjusted aggregate clawback will be $24 million less than what we would have spent if the drug coverage for dual eligibles remained under Medicaid.

In Conclusion:

From the beginning, Connecticut has taken a ?can do' attitude and has gone the extra mile to do everything it could to make the Medicare Rx program work for the state and the Medicare beneficiaries who reside in the State of Connecticut.

While implementation got off to a rocky start, we feel that most of the issues have been addressed or are in the process of being addressed by CMS.

The keys to the success in Connecticut have been open and frank communications among the constituents, their representatives, PDP's and federal/state officials. We appreciate and applaud CMS officials for their accessibility and understanding as we continue to move through issues important to the state and to our beneficiaries. Top officials at HHS/CMS including Dr. McClellan, CMS Administrator, Leslie Norwalk, CMS Deputy Administrator, Brian Cresta, HHS Region 1 Regional Director and Dr. Charlotte Yeh, CMS Region 1 Regional Administrator have accepted my calls and my questions at all hours and have worked diligently to provide responses.

Recommendations:

1. While the assessment of a penalty may have encouraged beneficiaries to enroll during this initial open enrollment period, it may prove counter-productive and actually discourage existing non-enrolled beneficiaries from enrolling in the future. Since beneficiaries, pharmacists and prescribers across the country are experiencing the impact of the Medicare Rx program for the first time, it may be wise for CMS to rethink the actual imposition of penalties.
2. Due to the time lag in transferring electronic files among state systems, PDP's, SSA and CMS, it may be more appropriate to establish enrollment target dates which include coverage effective dates during the next open enrollment. As a rule of thumb, beneficiaries should be informed that if they apply before the 10th of a month their coverage will be effective the first day of the next month. Conversely, if they apply after the 10th of a month, their coverage will be delayed until the following month. This would serve to lessen the anticipation of the beneficiaries and will eliminate the late enrollment, lack of system confirmation issues which crop up at the pharmacy counter.
3. While states and beneficiaries are gaining more insight into the formulary practices of the individual PDP's, other practices seem to be masked in a gray

area. CMS has made considerable efforts on communicating issues to PDP's and informing states of their pronouncements to the PDP's. States need to have a clear understanding of the requirements that CMS has imposed on the PDP's and what the consequences are for PDP non-compliance. As an example, there have been delays in the execution of PDP Trading Partner Agreements for the coordination of benefits and premium payments and in fact as of today, two PDP's operating in Connecticut still have not signed such agreements. As another example, while prescribers may issue a prescription for 90 days and the clients may wish to receive the 90 day supply, PDP's may not be honoring the full prescription. In addition, individual pharmacies may be choosing to fill less than the 90 day supply due to economic reasons related to PDP reimbursement for this 90 day supply. Clients or the state on behalf of the clients need to know what recourse they have in these situations.

4. While it is understandable that beneficiaries for legitimate reasons should be locked in a chosen PDP, beneficiaries with dramatic changes to their healthcare drug regimen may need to have an opportunity to re-select a plan which more appropriately covers their new drug regimen. With criteria, this exception for re-enrollment could be held to a minimum.
5. As an acknowledgement of the existing waste in unused pharmaceuticals in skilled nursing facilities, Connecticut implemented a strictly controlled nursing home drug return program. The program acquired certain unused Medicaid purchased medications dispensed in secure blister packs and re-dispensed the drugs through the original dispensing pharmacy. Based on the most recent experience, Connecticut was poised to save over $5M on an annual basis. While the drugs for dual eligibles residing in skilled nursing facilities are now paid for by Medicare, the state and the federal government have lost out on the ability to operate such a program. CMS should work with the PDP's to determine the final outcome of unused medications and work with the individual states to encourage them to establish a nursing home drug return program similar to the program operated in Connecticut. This program may be used as incentive program where states that have offered financial assistance to defray co pays for dual eligible clients or provided financial assistance for non-formulary drugs, may be allowed to share in these savings

On behalf of the State of Connecticut I would like to thank the members of this committee for their diligent oversight of the Medicare Rx program and their continued interest on the issues that beneficiaries and states are facing. In particular, I would like to acknowledge the work and participation of Connecticut's Congresswoman Nancy Johnson. Congresswoman Johnson has been an advocate for healthcare solutions especially for seniors. She has taken an active role in Connecticut with regard to the implementation of Medicare Rx and personally participated in numerous forums and enrollment activities. We are proud to have such an active advocate representing the interests of Connecticut's residents.

Thank you for inviting me to participate in these discussions and providing me the opportunity to showcase the efforts of Governor Rell, the legislature, my department and all of the stakeholders in doing our best to make Medicare Rx serve the beneficiaries in the great State of Connecticut.

Mrs. JOHNSON OF CONNECTICUT. Mr. Merritt.

STATEMENT OF MARK MERRITT, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

Mr. MERRITT. I would like to thank the Chair, Congressman Stark and other distinguished Members of the Committee. My name is Mark Merritt. I am president of the Pharmaceutical Care Management Association (PCMA). I am pleased to be here to discuss how pharmacy benefit managers (PBMs) in Part D plans are working with pharmacists and others to deliver safe and affordable prescription drugs to America's seniors.

Over the past 2 decades, private and public purchasers have turned to PBMs to help them manage drug spending and ensure

enrollees access to the medicines they need. Typically, PBMs save clients 25 percent on what they otherwise spend without our help. In fact, CMS actuaries recently found in 2004 drug spending slowed to slowest growth in 10 years. CMS specifically cited two products in PBM benefit design management, increased utilization of generics, and mail service pharmacies as key reasons for the slowdown in the rate of growth. PBMs do more than just save money. They improve quality too. PBM generic substitution programs inform consumers that they have more affordable alternatives immediately upon their arrival on the marketplace, and often even beforehand. PBM prescribing networks allow providers to review medication history and coverage information so we can help people not to over or underutilize their prescriptions. PBM drug utilization review programs make sure the people who take multiple medications aren't taking combinations of drugs that could be harmful.

Now, PBMs are putting these tools to work in Medicare. So far, the results are very promising with Part D premiums coming in almost 40 percent lower than projected and discounts on drugs being almost twice as deep as originally projected. In this regard, we are exceeding the expectations set by Congress and, according to recent surveys, we are also exceeding the expectations of beneficiaries themselves.

PCMA member plans have worked tirelessly with other stakeholders to get this new program up and running. As we all know, there were challenges and a degree of beneficiary and pharmacy confusion in the first few months. PBMs helped resolve these issues in several ways. First, plans provided 90 days of traditional assistance, transitional medicines to new enrollees in order to provide access to needed drugs. Second, plans waived co-pays or placed people on low co-pay tiers when information on eligibility and formulary status was unavailable.

Third, plans hired hundreds of additional call center staff to handle the high volume of calls and shorten waiting times. None of these activities were required by our contracts, and each of them added significant unanticipated and unreimbursed costs to our plans. We worked hard to help get the job done.

While we are proud of our efforts to date, there are over a number of policies which we do believe could undermine the ability of policy makers to sustain an affordable benefit in the future. For example, we believe that keeping the enrollment deadline firmly in place was not only essential to encourage enrollment but specifically motivated healthy seniors to enroll. This broadens the risk pool and encourages lower premiums down the road and furthers the notion that Part D is an insurance benefit, that everyone has a stake in, not just those who need prescriptions now.

Another potential problem is legislation under the guise of prompt pay that would mandate massive increases in generic dispensing fees, require plans to pay drug stores twice as fast as doctors and hospitals are paid in Medicare and mandate new restrictions on medication therapy management programs. This would cost taxpayers $9.4 billion according to our estimates, over 10 years without adding any corresponding value for beneficiaries.

Nonetheless, on the prompt pay issue, our industry took the lead to address prompt pay concerns by pledging publicly to pay pharmacy clean claims within 30 days, the same standard used throughout Medicare, the commercial market and incidentally, Community Care Rx (CCRX) the PDP that is run by the independent pharmacy industry itself. Generally, we believe consumers and payers win when contractual issues like how bills are paid are handled between plans and pharmacies, not micro managed by the government. That said, the job of the PBMs is to provide the best benefit possible given the resource limitations and guidelines made by policy makers. As in the commercial market, PBMs are problem solvers, resource stretchers and implementers which execute policy but obviously do not make it. I would like to thank, again, the Chair for the opportunity to testify and I would be happy to answer any questions you might have.

[The prepared statement of Mr. Merritt follows:]

Statement of Mark Merritt, President and Chief Executive Officer, Pharmaceutical Care Management Association

Good Morning Chairman Thomas, Ranking Member Rangel and all the Members of the Ways and Means Committee.

I am Mark Merritt, President of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 200 million Americans with health coverage provided through small businesses, Fortune 500 employers, health insurers, labor unions, and Medicare. PCMA member companies represent five national prescription drug plans (PDPs) and act as a subcontractor for other PDPs and Medicare Advantage plans.

I am pleased to discuss Part D plans' and PBMs' role in implementing and administering prescription drug benefits to America's seniors and disabled in Medicare. Before doing so, however, it is important to put this debate and PBMs' role into some perspective. From the early days of the Medicare prescription drug debate in the 1990s, policymakers from both sides of the political aisle—including both the Clinton and Bush administrations—have looked to PBMs for their expertise in successfully managing and negotiating pharmacy benefits. PBMs' tools and techniques were sought out for Part D because PBMs have a long and distinguished record of administering drug benefits in the commercial marketplace and have generated savings averaging 25 percent. PBMs generate increased efficiencies by leveraging their purchasing power on behalf of consumers and fostering price competition between drug manufacturers and retail pharmacies, where none previously existed and high prices were the norm.

Without question, 2006 has been a time of transition for all stakeholders—beneficiaries, physicians, pharmacists, employers, Part D plans, and the Medicare program itself. It has been challenging, but PCMA member plans have proven flexible in adjusting to changing rules and successful in meeting beneficiaries' needs. Our goals from the outset were to provide high quality, cost-effective drug coverage to Medicare beneficiaries, while proving able to maintain faith with the taxpayers who finance the benefit.

PBM'S PROVEN TRACK RECORD

PBMs' track record for delivering quality prescription drug benefits with generous savings for consumers and purchasers is a good one and one in which we are proud. PBMs generate savings and improve quality by using cost containment, clinical, and utilization-management tools designed to balance consumers' and purchasers' needs for affordability, choice, and access. Such tools include:

- Pharmacy and therapeutic (P&T) committee formulary development and review;
- pharmacy network management;
- negotiation and administration of product discounts, including manufacturer rebates;
- mail-service pharmacy;
- drug utilization review (DUR);
- generic substitution;
- clinical prior authorization and step therapy;

- consumer and physician education;
- disease management; and
- consumer compliance programs.

These tools are not unique to Medicare. Throughout the health care system, pharmacy management tools are recognized as essential to improving outcomes and ensuring value-based purchasing. Prior to the advent of these tools, there was no system-wide approach to addressing the real dangers associated with misuse, overuse, or underuse of prescription drugs nor with addressing runaway prescription drug costs.

PBMs' tools have delivered and the results cannot be denied. A recent study published in *Health Affairs* by CMS actuaries revealed that prescription drug spending in 2004 slowed to its lowest growth rate in the past 10 years, rising 8.2 percent. Since 1999 alone, the rate of growth in prescription drug spending has dropped by more than 50 percent. Overall, health spending grew in 2004 at a 7.9 percent clip, down from 8.2 percent in 2003.[1] The study's authors cited four key reasons for the slowdown in prescription drug spending:

- Rapid growth in the use of lower-price generic drugs;
- A shift toward greater mail-order dispensing;
- Increased use of over-the-counter medications; and
- Reduced consumption of certain drugs over safety concerns.

MEDICARE PART D: NEW CHALLENGES AND OPPORTINITY

Now plans and PBMs are bringing to Medicare the knowledge and experience developed through managing drug benefits in the commercial marketplace. The new Part D benefit approved by Congress in the Medicare Modernization Act of 2003 presents new opportunities and unique challenges for our industry.

The opportunities lie in the ability to extend the cost-saving and clinical management tools used so successfully in private plans to more than 40 million seniors and disabled Medicare beneficiaries. In this regard, we believe we have met and are exceeding expectations set by Congress and beneficiaries.

Part D Premiums Lower than Expected, Senior Satisfaction on the Rise

CMS recently reported that 38.7 million Americans now have Medicare prescription drug coverage, with over 2 million joining the program in the two weeks prior to the May 15 deadline. In addition, CMS reports that the average 2006 premiums actually paid by beneficiaries were much lower than actuaries expected at an average of $24 per month, compared with the previous estimate of $37 per month. Many believe that 2007 premiums will be even lower. Clearly, vigorous competition between Part D plans is driving significant savings for America's seniors.

Recent polling suggests that most seniors like the program. A recent *Washington Post/ABC News Poll* reported that 63 percent of seniors said they were saving money and 74 percent said they had an easy time enrolling in the program.[2] Another recent poll conducted by AARP found that 78 percent of those enrolled in a Medicare drug plan are satisfied with their plan.[3]

Part D Cost Savings Deeper than Expected

In an analysis of prescription drug-spending trends, CMS actuaries have found that program-wide, Medicare prescription drug plans (PDPs) are achieving deeper-than-expected discounts of 27 percent—up markedly from the 15 percent discount projection they made a year earlier. In turn, these discounts are driving overall estimates of prescription-drug trend lower. According to the report, total prescription drug expenditure growth for 2006 is revised downward from 8.1 percent to 7.7 percent to reflect actual Part D discounts available.[4]

PCMA conducted its own survey of five member plans discounts on the top 100 drugs used by seniors. Our own data shows that PCMA member PDPs are saving beneficiaries an average of 35 percent on medications purchased at retail phar-

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[1] Smith, Cowan, Heffler, et al, CMS National Health Accounts Team, National Health Spending in 2004: Recent Slow-Down Led By Prescription Drug Spending, *Health Affairs,* 25, no. 1 (2006: 186–196.

[2] "Most Seniors Enrolled Say Drug Benefit Saves Money," Jeffrey Birnbaum, Claudia Deene, The Washingoton Post, April 12, 2006 at http://www.washingtonpost.com/wp-dyn/content/article/2006/04/11/AR2006041101685.html

[3] "New Medicare Drug Benefit is Meeting or Exceeding Expectations," AARP News Release, April 12, 2006 at http://www.aarp.org/research/press-center/presscurrentnews/medicare _ drug _ benefit.html

[4] Borger, Smith, Truffer, et al, CMS National Health Accounts Team, "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs,* 25, no. 2 (2006): w61–w73.

macies and 46 percent for drugs dispensed through mail-service pharmacies when compared to pharmacy usual and customary prices.[5]

As we are all well aware, these results have not come without some effort. Implementing a program of this scale is a massive undertaking. We give Dr. Mark McClellan, Leslie Norwalk and all those at CMS great credit for the hard work they've done. Even with all the hard work, however, it would be unrealistic not to expect some challenges in the beginning.

Early Implementation Challenges Have Been Met

While we are all aware of the early implementation challenges with Part D—particularly in the opening weeks of the new benefit in January—we are pleased to report that most of these initial start-up problems have been resolved and the drug benefit is working much better for beneficiaries now.

During the first months of this year, PCMA member plans worked tirelessly with beneficiaries, pharmacies, physicians, and the Medicare program to identify key problems and address them as quickly as possibly. Among the key early issues challenging all stakeholders and how we have resolved them:

- **Data Files & Enrollment.** Part D plans were faced with data problems from the onset of enrollment. Some Medicare beneficiaries, particularly low-income and dual-eligible beneficiaries, were inadvertently enrolled in two different plans at the same time; due to late enrollment or incomplete files, some seniors did not get their enrollment information on time for the January 1 start date. These issues alone, as pharmacists and Members of this Committee are aware, created problems when beneficiaries showed up at the pharmacy counter without their drug card or with the wrong drug card. This, in turn, created long waits on telephone lines to clear up eligibility issues and link the right benefit with the right person. To address these challenges, PCMA member Part D plans hired hundreds of additional staff to answer pharmacist and customer-call lines.
- **Transitional Drug Coverage.** Part D plans have been flexible in working with beneficiaries and CMS to provide coverage for transitional medications. Part D plans were initially asked to provide 30-days of transitional medicines to new enrollees; we ultimately provided 90-day coverage of transitional medications. Plans waived co-pays or automatically placed individuals in low-copay tiers when information on eligibility and formulary status was missing.

PCMA recognizes that 2006 is a transition year for all stakeholders. While the real and substantial costs associated with data problems and transitional drug coverage were unanticipated and represent an added burden for Part D plans, our industry's willingness to work collaboratively with CMS and others underscores our commitment to making this benefit work for beneficiaries.

Medicare Part D Policy Issues Going Forward

While the initial implementation challenges are behind us, there are a number of other policy issues that—depending on how they are addressed—could undermine Medicare's ability to maintain an affordable drug benefit for beneficiaries.

Access to Generic Drugs

With great attention being given to drugs going off patent or losing exclusivity, PCMA recently examined the top 100 drugs used by seniors to arrive at a conservative estimate of potential Medicare cost-savings. Over the next five years, 14 brand-name drugs of the top 100 drugs commonly used by seniors to treat conditions such as high cholesterol, depression, heart disease, and hypertension are anticipated to go off patent or lose exclusivity. As soon as drugs become available in generic form, health plans and PBMs work collaboratively with patients, physicians, pharmacists, and payors to increase awareness about generic alternatives and potential cost-savings. Seniors and the Medicare Part D program could potentially save, at a minimum, more than $23 billion dollars over the next five years as at least 14 major brand-name drugs commonly used by seniors are slated to become available in generic form. However, PCMA remains concerned that these savings are at risk

[5] See "PCMA Analysis Finds Medicare Prescription Drug Discounts ?Real & Holding Steady' in First 30 Days" at http://www.pcmanet.org/newsroom/2006/pr _ 1 _ 06/pr _ 2 _ 06/pr _ 20706.htm. NOTE: PCMA's study compared only PCMA member plan PDPs prices for the top 100 drugs used by seniors to average retail usual and customary drug prices found on the New York Attorney General's prescription Drug website at: http://www.nyagrx.org/. This study is not meant to be a comprehensive actuarial analysis of Medicare savings but a snap shot of possible savings available to beneficiaries compared to cash-paying customers. CMS analysis is based on the entirety of drug benefit savings including premiums paid, administrative costs, drug utilization and other factors.

in the coming years as some special interest groups continue efforts aimed at undermining generic alternatives, both in public programs and the commercial marketplace.

Mail-Service Pharmacy

The mail-service pharmacy option is an important tool for individuals managing chronic conditions. The 90-day mail-order pharmacy option offers increased savings and, since medications can be automatically delivered as each fill ends, helps consumers better comply with their prescription regimen. Mail-order pharmacies also have great savings potential. According to an August 2005 report from the Lewin Group, mail-order pharmacies provide savings of an additional 10 percentage points compared to retail pharmacies, based on a review of the published evidence. At the current level of market penetration, mail-order pharmacies will save the health care system $78.9 billion in drug expenditures from 2006–2015. PCMA believes strongly that policymakers should resist efforts to erode this important cost-saving option for beneficiaries.

Drugstore Lobby Agenda

Regrettably, after initially opposing the Medicare prescription drug benefit, the drugstore lobby is now pushing legislation on a variety fronts that would increase costs:

- *Prompt Pay/MTM/Increased Dispensing Fees.* The drugstore lobby is pushing legislation that would mandate increased generic dispensing fees, require pharmacy payment within 14 days or less; and place new restrictions on Part D's Medication Therapy Management (MTM) program. This legislation would cost the Medicare program at least $9.4 billion in added costs, with no corresponding benefit to seniors. Of that amount, $7.7 billion would be new federal Medicare outlays while $1.7 billion would come from increased beneficiary premiums. The majority of these additional costs result from new MTM requirements. Prompt payment of Medicare claims is a priority for Part D plans. In light of the expressed concerns that some pharmacists were not being paid in a timely manner, PCMA member companies recently publicly pledged to pay pharmacies submitting clean electronic Part D claims within 30 days.[6] Payment within 30-days is the industry standard for payment of clean claims filed electronically for doctors, hospitals, and other providers in Medicare Parts A & B; it is the pharmacy-claims standard in 43 states; and it is the standard applied to the Federal Employees' Health Benefit Plan (FEHBP), Members of Congress' own health plan.
- *New Collective Bargaining Rights for Independent Pharmacies.* The independent pharmacy lobby is pushing legislation, HR 1671, that would provide independent pharmacies with unprecedented and sweeping collective bargaining rights, both in the commercial marketplace and in Medicare. This proposal is one of the most anti-consumer proposals introduced in this Congress and would effectively provide independent pharmacies a license to collude to raise prescription drug prices, including Medicare beneficiaries. Furthermore, this proposal would grant pharmacies all the benefits and none of the obligations under the National Labor Relations Act. PCMA strongly opposes an antitrust exemption for independent pharmacies, both in the commercial marketplace and in Medicare.

Elimination of the Late Enrollment Penalty

As 2006 is a transition year, PCMA recognizes that flexibility from all stakeholders in Part D is critical. For this reason, PCMA does not oppose the elimination of the late enrollment penalty for 2006. However, going forward in later years, eliminating this penalty would be problematic.

Pharmacy Management Tools

Pharmacy management tools are a proven avenue to lower drug costs and expanded access. It is critical that any changes to Part D, either through legislation or regulation, are done in the spirit of reflecting the commercial methods for administering prescription drug benefits. This basic principle of Part D is particularly important when considering the regulation of formularies and other PBM tools, including step therapy, quantity limits, and prior authorization. The less flexibility given to Pharmacy and Therapeutics (P&T) committees in designing formularies and uti-

[6] See "PCMA Member Companies Pledge to Pay Medicare Pharmacy Claims Within 30 Days," at http://www.pcmanet.org/newsroom/2006/Pr _ 5 _ 06/pr _ 05 _ 05.htm

lizing other tools, the less effective the formulary will be with respect to quality improvement and cost-savings.

CONCLUSION

PCMA and its member plans are proud of our achievements in the first five months of this historic new program and the support we have provided to beneficiaries. While all stakeholders have faced challenges along the way, a spirit of collaboration and cooperation among beneficiaries, pharmacists, physicians, plans, CMS, and others has prevailed and allowed us to resolve early challenges. We believe the services we provide and the results we are seeing speak to the high standards we place on quality and affordability. In short, we believe we are doing the job Congress and America's Medicare beneficiaries have asked us to do.

I appreciate the opportunity to testify and am happy to answer any questions Members may have.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much. Mr. Pollack.

STATEMENT OF RONALD POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

Mr. POLLACK. Thank you, Madam Chairman. I am delighted to join you. I am going to focus on three issues during my brief testimony. The first pertains to enrollment with respect to low-income people who are eligible for special subsidies. Secondly, I want to focus on drug prices, and thirdly, I want to talk about how help should be provided with respect to navigating the complexity of Medicare generally, and Part D specifically. With respect to low-income participation, there has been testimony today concerning what portion of the low-income population is actually enrolled in coverage and is receiving the special subsidies to which they are eligible. I think all of us, irrespective of our views about the legislation, believe that the most important facet of the program is to provide protection and coverage for low-income people. It is for that reason that it is extraordinarily disappointing to see what the performance is with respect to low-income seniors.

As was discussed at different times today, there are two different groups of low-income seniors. There are those seniors who have some connection to the Medicaid program, and there are those who do not have a connection to the Medicaid program and that group of people has to affirmatively enroll in coverage. It is that latter group where the performance is extraordinarily disappointing. Only 1.8 million people have signed up or have been enrolled with respect to low-income subsidies. There are approximately 7.2 million people who are eligible for those subsidies, which means that only one out of four people who are eligible for these subsidies are now receiving them. On Page 5 in my testimony, you will see the State-by-State numbers.

In Connecticut, it is 25 percent out of 62,000 people eligible, only a little over 15,000 have enrolled. In Louisiana, there are 165,000 people eligible, only approximately 39,000 have enrolled, 24 percent. In California, there are 421,000 people eligible, only 97,000 have enrolled, approximately 23 percent. In the State of Washington, it is 21 percent. In Texas, you are doing somewhat better. Mr. Doggett, since in Texas it is 37 percent. Still these numbers are extraordinarily low.

One of the things worth pointing out, is the Administration is actually saying there are relatively small numbers of low-income people who haven't enrolled. Look at this extraordinary, assertion is Mr. McClellan's testimony. On page 11, he has a chart that shows what portion of low-income people are participating in the program. One of the things that is rather extraordinary is that the Administration, for over a year, has been saying there are 14.4 million people who are eligible for low-income coverage, and it was only in May of 2006 that the Administration actually changed that estimate to 13.2 million people. To the extent that the Administration is telling us the performance is better, part of it is by changing the denominator, with no explanation whatsoever, in terms of those people who are eligible. The Administration provided new numbers for the first time of people who supposedly have creditable coverage but have not enrolled in the program. Unfortunately, those people are not receiving the subsidies that are critically important in order to make drug coverage affordable for them.

I want to say a word about drug prices. We have been hearing throughout the course of this hearing that prices are coming down. Two words: Not true. We are going to release a report in about 10 days that takes a look at each of the Part D plans for all of the major drugs that are prescribed for seniors. What you are going to see is that the prices in Part D plans have increased, and we will show it plan by plan, drug by drug. These are all figures that have been provided by the plans to CMS. These price are going up.

It is true that the average premiums are somewhat lower than were expected. This is not because prices have come down as a result of competition. To illustrate that fact, like the situation of my mother-in-law. When I enrolled my mother-in-law, I put her in the cheapest plan, which was a Humana plan. She doesn't need substantial drugs. As people like my mother-in-law enrolled, in terms of weighted averages, it looks like the prices have come down. Not true. There are a lot of people who are signing up for plans and are doing so by enrolling in plans with the cheapest premiums, but it doesn't mean that the prices of drugs are coming down. What our report will show is not only that this is an enormous difference between the prices that the Veterans Affairs (VA) has been able to secure through negotiation, but the prices in Part D plans are coming up since the program began.

I want to just say one last word about one other facet about the program. This program is complex. It is probably going to continue to be complex. One of the things I think all of us, irrespective of our opinions, should try to do is to make sure that seniors have help navigating the program. I think there is nothing more important than providing direct one-on-one counseling for seniors. I think it was Congressman Larson who was talking about the State Health Insurance Assistance Program (SHIP) programs that provide a yeoman service in terms of helping people sign up. It is my hope, Madam Chairman, that irrespective of our points of view, let us provide the resources to the SHIP program so that they can get the job done so that we successfully help seniors who are looking for assistance. I am hopeful that that will be included as part of any legislation that might eliminate the penalty for those people who have not signed up.

Mrs. JOHNSON OF CONNECTICUT. Thank you, Mr. Pollack.
[The prepared statement of Mr. Pollack follows:]

Statement of Ronald Pollack, Executive Director, Families USA

Families USA thanks the Committee on Ways and Means for the opportunity to present testimony on the implementation of Medicare Part D, Medicare's prescription drug program. This testimony focuses on three aspects of the program's implementation: enrollment in the low-income subsidy; the drug prices charged by the participating drug plans; and the needs of the State Health Insurance and Assistance Programs.

Low-Income enrollment deeply disappointing

One of the few sources of agreement among all sides in the debate surrounding the Medicare prescription drug benefit was that low-income seniors could be helped substantially by the assistance promised in the low-income subsidy that accompanies Part D. This is a very generous benefit that can make a real difference in the lives of some of the most vulnerable seniors.

Unfortunately, enrollment in this program has been very disappointing. Families USA issued a report last month that examined the pace of enrollment in the low-income subsidy in each state. We have updated the primary table from that report with the most recent publicly available enrollment data and included it in this testimony at Table 1. Approximately 7.2 million beneficiaries are eligible for the subsidy and will not be automatically enrolled. As of May 26, 2006, the Social Security Administration reports that 1.8 million beneficiaries—or only one out of four of those eligible—have been approved for the benefit. This means that over five million of our neediest seniors remain without the help promised to them by Congress and the Administration.

Interestingly, although the Centers for Medicare and Medicaid Services (CMS) agrees that a large number of low-income seniors remain without Part D coverage, during the past month they have shrunk their estimates of the numbers eligible for the program by about two million. These lower figures come from two changes that were announced as the initial enrollment period was drawing to a close. First, in early May, CMS announced that it was reducing its estimate of the total number of low-income Medicare beneficiaries (including full dual eligibles) from the 14.4 million published in the Federal Register in January 2005 to 13.2 million. Second, CMS is counting about one million low-income seniors who have some form of creditable drug coverage as not needing the help provided by the low-income subsidy. The majority of these one million are veterans believed to have coverage through the Department of Veterans Affairs (VA). It is unclear whether CMS has confirmed that these beneficiaries are actually receiving coverage from the VA or are simply eligible for VA coverage. Moreover, although VA coverage is as good as or better than the basic Part D benefit, it may not be as good as the coverage available to them with the low-income subsidy. It is therefore misleading to count all of these needy beneficiaries as having low-income coverage. CMS should reexamine its methodology for estimating the number of beneficiaries eligible for and covered by the low-income subsidy.

Nevertheless, by any estimate, there is no doubt that getting prescription drug coverage to low-income seniors remains a large and difficult unfinished job. The Administration needs to redouble its efforts in this area, and Congress should make sure that adequate resources are available. In the longer term, eliminating the assets test would simplify eligibility determinations, by requiring only the assessment of a beneficiary's income. Two other interim steps could help as well: 1) eliminating the cash value of life insurance as an asset; and 2) eliminating in-kind support (such as housecleaning by a grandchild) as countable income.

Dual Eligibles Remain Vulnerable

Dual eligibles are Medicare's most vulnerable beneficiaries. Their Medicaid drug coverage ceased when Medicare Part D began on January 1, 2006, and the initial difficulties they faced obtaining drugs under the new program are well documented.[1] What is less well understood is that dual eligibles continue to face obstacles that limit their access to prescription drugs under Part D. More than half of all dual eligibles face higher copayments than they did under Medicaid. And all dual eligibles will have to navigate the formularies and utilization management rules im-

[1] See, e.g., Vernon Smith, et al., *Observations on the Initial Implementation of the Medicare Prescription Drug Program* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2006).

posed by Part D plans—formularies and utilization management rules that are more restrictive than what they experienced in Medicaid. Finally, tens of thousands of seniors become dually eligible each month. Although some of the most egregious technical glitches have been remedied, dual eligibles across the country continue to encounter situations where the enrollment process does not work properly and they are unable to obtain prescription drugs. Table 2 of this testimony provides an estimate of the number of dual eligibles enrolled in Part D in each state, based on the most recent data available from CMS.

Drug Prices Continue to Climb

The Medicare prescription drug program is built around the theory that competition among competing Part D providers will bring down drug prices. This is why the Medicare Modernization Act prohibited Medicare from negotiating directly for lower prices on prescription drugs. Families USA has been monitoring the drug prices that the various Part D plans charge to consumers since enrollment in the Part D program began in November 2005. We will be releasing a report next week that examines the trends in Part D drug prices during the first six months of the program. It will show that drug prices in the overwhelming majority of plans have increased substantially. Moreover, it will show that the differences in prices between what the VA pays and what Part D pays are enormous. As a result, both seniors in Part D plans and American taxpayers continue to overpay for prescription drugs.

There are several steps that could address the problem of high prescription drug prices. As a first step, Congress and the Administration should make the prices that Part D plans pay transparent. Under current law, every Part D plan negotiates its own price for the drugs it covers with the pharmaceutical manufacturer. Although the plans are required by law to pass a portion of the discounts they receive on to beneficiaries, the proportion of that discount is not specified. Moreover, the plans are not required to report publicly the discounts they receive for specific drugs. They only report the prices they charge consumers. Part D plans could in fact be negotiating substantial discounts on the drugs they cover, but retain these savings for themselves. Making information about these discounts publicly available would provide more complete information about the relationship of competition and prices for prescription drugs.

In the longer term, Congress and the Administration need to repeal the prohibition on Medicare's negotiating directly for prescription drug prices and replace it with a directive to require such negotiations. Pooling the purchasing power of 43 million beneficiaries will result in lower prices for Medicare beneficiaries and savings to American taxpayers. These savings could be used to improve the Part D benefit—for example by filling in the doughnut hole and eliminating the asset test for low-income beneficiaries.

Consumers Will Need Help with Ongoing Challenges

Even though the initial enrollment period for Part D ended on May 15, the need to counsel and educate Medicare beneficiaries has not abated. Thousands of seniors become newly eligible for Part D each month. The millions of seniors who missed the May 15 deadline need to be advised of their options. Those eligible for the low-income subsidy can apply during the year. Others will face a penalty when the next open enrollment period arrives in November. And all beneficiaries will need help sorting though the confusing array of Part D choices.

In addition, the millions currently in Part D plans are now making their way through the often-byzantine rules of their plans. All plans impose some forms of utilization management, such as prior authorization rules and quantity limits, which limit access to drugs. These policies appear to be more restrictive than those in traditional private insurance plans.[2] Beneficiaries can challenge these rules in cases of medical necessity, but doing so requires going through a complicated exceptions and appeals process, which can leave beneficiaries and their doctors confused and overwhelmed. In addition, prices can and do change throughout the year. Each month, more beneficiaries will enter the doughnut hole and be faced with paying their Part D premium while at the same time paying full price for their drugs.

During the first few months of Part D implementation, information about the program from Medicare has been at times incomplete or confusing.[3] But seniors do not

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[2] "Medicare patients confronting drug restrictions," *Associated Press,* March 30, 2006 (available online at www.msnbc.msn.com/id/12080177).

[3] United States General Accountability Office, *Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved,* (Washington: General Accountability Office, May 2006).

have to navigate these various challenges on their own. The State Health Insurance and Assistance Programs (SHIPs) exist in each state to help Medicare beneficiaries resolve problems with their health coverage. These agencies, primarily staffed by volunteers, have been on the front lines during the first months of Part D implementation, helping confused seniors sort out the details of Part D. SHIPs have been deluged with requests for help since Part D began. In California, for example, the SHIP served more than three times the number of beneficiaries in January 2006 than it did in all of 2005.[4] Nationwide, call volume to SHIPs has more than doubled through the first few months of the year. Moreover, SHIPs will continue to serve Medicare beneficiaries long after the initial rush of enrollment is over, and they need additional support. At the least, SHIPs should be funded at $1 per Medicare beneficiary—a minimal amount given the vital services they provide and the overwhelming demands on their resources.

Summary: Action Steps for the Future

There are a number of actions that Congress should take to improve the Part D program. They include:

- Giving Medicare authority to negotiate for lower drug prices on behalf of 43 million beneficiaries;
- Closing the coverage gap (or "doughnut hole");
- Eliminating the assets test for low-income beneficiaries;
- Eliminating the cash value of life insurance as a countable asset for low-income beneficiaries;
- Eliminating in-kind support as countable income for low-income beneficiaries;
- and Increasing funding for SHIPs to at least the level of $1 per beneficiary.

Thank you to the Committee for the opportunity to present this testimony.

Table 1: Enrollment in the Low-Income Subsidy, through May 26, 2006

State	Number Estimated Eligible	Number Approved as of 5/26/06	Percent Approved
Alabama	181,000	47,415	26%
Alaska	8,000	2,319	29%
Arizona	159,000	20,669	13%
Arkansas	89,000	37,011	42%
California	421,000	97,340	23%
Colorado	80,000	22,743	28%
Connecticut	62,000	15,370	25%
Delaware	20,000	6,962	35%
District of Columbia	14,000	2,802	20%
Florida	542,000	110,390	20%
Georgia	244,000	68,002	28%
Hawaii	28,000	8,496	30%
Idaho	50,000	8,469	17%
Illinois	296,000	66,625	23%
Indiana	164,000	48,480	30%
Iowa	88,000	18,456	21%

[4] Ibid.

Table 1: Enrollment in the Low-Income Subsidy, through May 26, 2006—Continued

State	Number Estimated Eligible	Number Approved as of 5/26/06	Percent Approved
Kansas	80,000	17,913	22%
Kentucky	118,000	51,808	44%
Louisiana	165,000	39,219	24%
Maine	45,000	7,765	17%
Maryland	110,000	34,661	32%
Massachusetts	113,000	31,273	28%
Michigan	256,000	59,059	23%
Minnesota	114,000	19,440	17%
Mississippi	98,000	28,082	29%
Missouri	170,000	41,038	24%
Montana	35,000	7,196	21%
Nebraska	46,000	10,893	24%
Nevada	52,000	12,014	23%
New Hampshire	36,000	8,918	25%
New Jersey	180,000	56,649	31%
New Mexico	64,000	14,058	22%
New York	435,000	98,201	23%
North Carolina	245,000	87,195	36%
North Dakota	25,000	6,949	28%
Ohio	340,000	72,356	21%
Oklahoma	117,000	30,794	26%
Oregon	96,000	19,877	21%
Pennsylvania	397,000	76,358	19%
Rhode Island	33,000	7,250	22%
South Carolina	150,000	43,719	29%
South Dakota	29,000	5,874	20%
Tennessee	143,000	40,893	29%
Texas	485,000	178,221	37%
Utah	37,000	7,964	22%
Vermont	—	4,946	100%
Virginia	177,000	57,335	32%

Table 1: Enrollment in the Low-Income Subsidy, through May 26, 2006—Continued

State	Number Estimated Eligible	Number Approved as of 5/26/06	Percent Approved
Washington	124,000	26,576	21%
West Virginia	102,000	22,899	22%
Wisconsin	131,000	18,908	14%
Wyoming	16,000	3,061	19%
Total—United States	7,218,000	1,830,911	25%

Sources: Estimates of eligibility from Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes* (Washington: National Council on the Aging, 2005). Number approved from Social Security Administration, "SSA Completed Decisions by State" (Data as of 5/26/06), available at www.ssa.gov/legislation/statealphasmallfont.html. An earlier version of this table appears in Marc Steinberg, *Special Report: The Medicare Drug Program Fails to Reach Low-Income Seniors* (Washington: Families USA, May 2006), available at www.familiesusa.org.

Table 2: Dual Eligibles Enrolled in Part D, by state, as of May 7, 2006

State	Estimated Number of Dual Eligibles
Alabama	99,284
Alaska	11,611
Arizona	81,131
Arkansas	68,170
California	1,015,227
Colorado	56,662
Connecticut	71,080
Delaware	10,530
District of Columbia	16,145
Florida	410,811
Georgia	153,822
Hawaii	28,494
Idaho	20,762
Illinois	262,726
Indiana	102,371
Iowa	59,343
Kansas	42,768
Kentucky	91,630
Louisiana	109,441

Table 2: Dual Eligibles Enrolled in Part D, by state, as of May 7, 2006—Continued

State	Estimated Number of Dual Eligibles
Maine	46,738
Maryland	62,556
Massachusetts	199,054
Michigan	202,580
Minnesota	74,579
Mississippi	131,277
Missouri	158,443
Montana	16,133
Nebraska	33,608
Nevada	26,588
New Hampshire	20,297
New Jersey	146,424
New Mexico	39,052
New York	559,701
North Carolina	233,817
North Dakota	11,420
Ohio	204,596
Oklahoma	80,710
Oregon	48,385
Pennsylvania	203,373
Rhode Island	31,418
South Carolina	119,802
South Dakota	12,747
Tennessee	228,052
Texas	346,831
Utah	23,564
Vermont	16,398
Virginia	113,831
Washington	107,181
West Virginia	46,004

Table 2: Dual Eligibles Enrolled in Part D, by state, as of May 7, 2006—Continued

State	Estimated Number of Dual Eligibles
Wisconsin	116,356
Wyoming	6,041
Total—United States	6,379,564

Source: Families USA calculations based on "State Enrollment in Prescription Drug Plans Nov. 15, 2005—May 7, 2006," available online at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02 _ EnrollmentData.asp # TopOfPage, released May 10, 2006. An earlier version of this table appears in Marc Steinberg, *Special Report: The Medicare Drug Program Fails to Reach Low-Income Seniors* (Washington: Families USA, May 2006), available at www.familiesusa.org. The methodology underlying these calculations is discussed in the report.

Mrs. JOHNSON OF CONNECTICUT. We have 3 minutes left to vote. If Members haven't left, they need to leave. We will have to recess, unfortunately, for about 20 minutes. There are seven 2-minute votes, plus the conclusion of this vote, so it will be 20 to 25 minutes. I apologize for that, but there is some good discussion that we need to have among the panelists as well as some with the panelists and the Members. We will be right back.

[Recess.]

Mrs. JOHNSON OF CONNECTICUT. The hearing will resume. Your testimony has been very valuable. We will now hear the concluding comments of the three witnesses who have not yet testified. Just going to suspend a moment. Will you proceed, please?

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMERICA'S HEALTH INSURANCE PLAN

Ms. IGNAGNI. Thank you, Madam Chair. As both of you know, our members provide prescription drug program coverage for regular, advanced, and coverage of the special means population. We have planned to simplify and create and inform about the administrative procedures. First, I would like to comment a bit about the effectiveness of the program savings, and then I would like to devote most of my time to the challenges of what we found and what we did to address them.

First, a couple of notes have been raised, for it is worth noting that only 10 percent have chosen the statutory package. All other beneficiaries have chosen packages which exceed what Congress laid out in the Medicare Modernization Act of 2003 (P.L. 108–173). That means lower premiums. That means lower deductibles, better cost sharing, and, in many cases, coverage in the coverage gap.

There has been a great deal of discussion about savings. I am not going to belabor that. There have been some important studies done by PriceWaterhouseCooper, CMS, Consumer Union, and others to well chronicle those savings. They are particularly important for low-income individuals. Now, to the matter that the Committee

is probing, which are the challenges that we encountered and what do we do about them. First, we encountered unanticipated call volume. We recognized that we needed more people very quickly. We recognized that we needed more training and we began monitoring the results. In our testimony, you have the data that we have provided. We have been monitoring very closely the results. Speed to answer has gone from 8 minutes on the pharmacy lines in January to 30 seconds in May. On the beneficiary lines, 11 minutes in the same period of time to 2 minutes.

We also encountered systems challenges in the first weeks of the program. CMS worked 24/7. They brought in Electronic Data Systems Corporation (EDS). It was the right thing to do. We worked hand in hand with them and mobilized the best in the industry to address these problems. Notwithstanding that effort, there were four aspects of the systems issued that materialized: clearly, delays in beneficiaries being enrolled, delays in clarifying eligibility for low-income assistance as well as subsidy as well as dual eligibility, delays at the pharmacy and confusion in beneficiaries' minds.

What this caused us to recognize was three things. First, that the transition had to be extended, and we supported that, very affirmatively. Second, that we needed to send a strong message to States that they would be made whole, and we did that very carefully and clearly. Third, we needed to have an organized outreach to pharmacy organizations and beneficiary groups to understand their issues, and we formed advisory Committees to do that. We launched an unprecedented uniformity initiatives in four areas.

First, we realized that we needed to have a common trigger for exceptions and appeals that physicians could use all over the country notwithstanding what plan they were affiliated with. We have done that working hand in hand with the American Medical Association and the Committee that they brought together with a very important group of beneficiary advocates and others.

Second, we realized that we had to standardize pharmacy messaging. We worked over an 8-week to 10-week period with the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists Assocaition (NCPA), the pharmacy organizations, to get that done; and we worked again with important organizations. Mark Merritt, my colleague, is here and he played a very important role in that as well.

Third, we realized that there needed to be a form, a standard form for beneficiaries to request reimbursement when they have paid out of pocket in cases where they shouldn't have. We delivered that. Fourth, we have been very much involved with consumer organizations, pharmacy organizations, and others in the formation of the Pharmacy Quality Alliance. There are two other areas we encountered: first, concern about formularies. We needed to communicate very, very clearly that our members supported the principles of providing continuity of care. There was a board statement that we passed, CMS-issued guidance. We supported that very affirmatively. Second, the issue of pharmacy payment. There are two areas that have been flagged by pharmacists in the area of frequency, and the area of electronic payment. We just issued a statement last week on the part of our board of directors. We have endorsed a series of very specific best practices with respect to bimonthly cash

flow, that no payment should be later than 30 days, and we have talked about embracing an electronic fund transfer. We would be very comfortable with CMS guidance along these lines.

In conclusion, Madam Chair, our community worked hard to deliver effective coverage. We worked hard to respond to unanticipated challenges and do it as effectively and as quickly as we could. We worked hard to put in place partnerships that I think will provide a strong foundation for our industry to continue to keep our ear to the ground on issues that we need to address. We will be doing exactly that. Thank you.

Ms. JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Ms. Ignagni follows:]

Statement of Karen Ignagni, President and Chief Executive Officer, American Health Insurance Plans

I. INTRODUCTION

Good morning, Chairman Thomas, Ranking Member Rangel, and members of the committee. I am Karen Ignagni, President and CEO of America's Health Insurance Plans (AHIP), which is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace, have a strong track record of participation in public programs, and are strongly committed to the long-term success of the Medicare Part D prescription drug program.

Today, almost 39 million Medicare beneficiaries have prescription drug coverage. Early on in the enrollment process, our members realized that the scale and scope of this program required an unprecedented level of collaboration and innovation by health plans and an organized effort to reach out and forge partnerships with important stakeholder groups.

In our testimony today, we will focus on:

- the specific steps AHIP members have taken, in collaboration with other partners, to improve the transition and strengthen the Part D program;
- the savings and value the Part D program is delivering to both beneficiaries and taxpayers; and
- what surveys show about the views of beneficiaries who are enrolled in Part D plans.

II. STEPS HEALTH PLANS HAVE TAKEN TO IMPROVE THE TRANSITION AND STRENGTHEN THE PROGRAM

To prepare for implementation of the Part D program, AHIP's members organized early and worked across the industry to ensure that beneficiaries would be well-served by the new drug benefit. As discussed below, we have been working actively to strengthen the program and ensure a smoother transition for beneficiaries. By identifying opportunities for improvement—and initiating collaborative ventures with key partners—plan sponsors have taken important steps to promote a stable Part D program that is delivering substantial value to beneficiaries.

Recognizing the Need to Reach Out to Key Stakeholder GroupsK

Early this year, AHIP and our members established two new advisory groups to pro-actively address implementation issues that have been raised by pharmacists and beneficiary groups. We took the initiative in forming these groups, because we recognized the need for greater collaboration between key stakeholder groups during the initial implementation phase of the Part D program.

The Pharmacy Issues Advisory Group is a collaboration between AHIP members, the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacists' Association (NCPA). This group is addressing pharmacists' concerns on Part D issues, including the need for clarity and uniformity in the communications they receive from plans. As discussed below, this effort already has yielded a significant agreement on standardized messaging that is improving the flow of information to pharmacists and, as a result, allowing beneficiaries to have their prescriptions filled more quickly and effectively.

Through another collaborative effort—the Beneficiary Issues Advisory Group—AHIP members have been engaged in a dialogue with a wide range of beneficiary advocates. These discussions are leading to progress in several key areas: improving

beneficiary information; reimbursing beneficiaries for certain out-of-pocket costs; and creating a streamlined approach for surrogate decision-makers to act on behalf of beneficiaries. This group also provides a forum for improved understanding of complex issues such as the appropriate use of formularies, coverage determinations, and grievances and appeals.

Recognizing the need for Uniform Processes

Standardizing Messages for Pharmacists: In late February 2006, AHIP joined the NACDS and the NCPA in jointly recommending to the National Council for Prescription Drug Programs (NCPDP) standardized electronic messaging designed to promote the consistent use of key terms by Part D plans to assist pharmacists in better serving beneficiaries. NCPDP adopted our initial recommendation to develop new codes for notifying pharmacists in clear, understandable terms when drugs are statutorily excluded from Part D basic benefits or are covered under Part B.

On April 18, AHIP, NACDS, and NCPA announced an agreement on additional standardized electronic messages to help pharmacists quickly determine the appropriate course of action for filling beneficiaries' prescriptions under four different circumstances: (1) when a particular drug is not covered; (2) when prior authorization is required; (3) when plan quantity or other coverage limitations have been exceeded; and (4) when the pharmacy is not part of the Part D plan's network. Based upon this agreement, we are continuing to work within the NCPDP process towards adoption of improved messaging for pharmacists in these areas.

AHIP member organizations are committed to working in collaboration with other key stakeholders on implementation of standardized messaging. We believe this initiative can strengthen the program by helping to eliminate a possible source of confusion for pharmacists, thus allowing them to provide more prompt and effective service to beneficiaries.

Simplifying the Exceptions Process: On another front, AHIP and the American Medical Association (AMA) recently announced a standard form to simplify the process by which physicians can request prior authorization and coverage of most non-formulary drugs under the Part D program. This standard form was developed through the collaborative efforts of plan sponsors, an AMA work group, and several beneficiary advocates. The Centers for Medicare & Medicaid Services (CMS) now requires all Part D plans to accept the standard form to initiate requests for coverage determinations. Meanwhile, AHIP members are continuing to work with the AMA and other partners on additional steps to streamline the process of seeking coverage determinations for specialty drugs that require more information

In addition to AHIP members and the AMA, other organizations involved in this collaboration include the American Psychiatric Association, the American Academy of Family Physicians, the American College of Physicians, the Medical Group Management Association, the National Council on the Aging, the Center for Medicare Advocacy, the Alzheimer's Association, the American Pharmacists Association, and the American Society of Consultant Pharmacists.

The agreement on this standard form is an important step toward ensuring that physicians know how to help beneficiaries obtain their medications on a timely basis. It also clearly demonstrates our industry's strong commitment to simplifying administrative procedures and improving uniformity wherever possible.

Simplifying the Refund Process for Beneficiaries: On another key issue, our discussions with the Beneficiary Issues Advisory Group have led to the creation of a standard form that beneficiaries can use to request refunds in instances where they were inappropriately charged higher coinsurance early in the year because CMS systems had not yet identified them as low-income beneficiaries who are eligible for lower cost-sharing. This one-page form helped to simplify the refund process for those beneficiaries who were seeking reimbursement for overpayments they made.

Ensuring Continuity of Care for Beneficiaries

Plan sponsors took the initiative in adopting transition plans in January to ensure that beneficiaries continued to receive an initial prescription for covered Part D drugs they had been taking that otherwise would have been subject to formulary rules. This was an important step toward ensuring continuity of care for beneficiaries during the initial implementation of the program. Plans subsequently supported CMS' decision to extend these transition policies through a 90-day period that ended on March 31.

More recently, on April 27, AHIP's Board of Directors issued the attached statement (see Appendix A) endorsing the principle of providing continuity of care for beneficiaries enrolled in the Medicare Part D prescription drug program. This statement demonstrates our members' strong commitment to ensure continuity of prescription drug coverage for beneficiaries and, at the same time, use formulary man-

agement techniques to maximize the quality and cost-effectiveness of the Part D drug benefit.

This policy was developed to give beneficiaries the peace of mind of knowing that they will be able to continue to receive their Part D formulary drugs throughout the year and is consistent with CMS guidance. The statement also discusses the importance of providing Medicare beneficiaries with a prescription drug benefit that reflects the latest scientific evidence regarding the efficacy of various medication therapies, side effects and adverse reactions, interactions among medications, and disease-specific concerns.

The statement further emphasizes that there are certain circumstances under which formulary changes for existing enrollees are justified to protect the health of beneficiaries or enable them to receive greater value. This includes when safety or efficacy concerns have been identified by the Food and Drug Administration (FDA) and/or the plan's Pharmacy and Therapeutics Committee based upon scientific evidence, and when an FDA-approved generic alternative to a brand name drug becomes available.

Supporting Pharmacists Through Timely Payment of Part D Claims

Our members also recognize the important role pharmacists play in ensuring that beneficiaries are well-served by the Part D program. On June 7, AHIP's Board of Directors approved the attached statement (see Appendix B) in support of implementation of best practices that will promote effective working relationships with pharmacies and timely payment of their claims. This statement indicates that health plans providing prescription drug coverage to Medicare beneficiaries are committed to supporting the following best practices.

This AHIP Board statement emphasizes that plans will work with pharmacy benefit managers (PBMs) to ensure that payments for "clean" claims are transmitted via mail or electronic funds transfer (EFT) to pharmacies at least twice per month and that payments for all "clean" claims are transmitted via mail or EFT no later than 30 days after the claims are submitted by the pharmacy.

The statement further indicates that plans will work with PBMs and the pharmacy community to promote the availability and utilization of EFT. Since maximum efficiency results from the combination of EFT and the transmittal and acceptance of electronic remittance advice, we will work collaboratively to promote the use of both of these electronic transmittals.

This Board statement reflects our industry's strong commitment to establishing a good-faith partnership with our nation's pharmacists as part of our comprehensive efforts to promote stability—and value for beneficiaries—in the Part D program.

Improving Quality at the Pharmacy Level

AHIP members also are active participants in the PQA initiative announced on April 19 by CMS Administrator Mark McClellan, M.D., Ph.D. The PQA will focus on selecting measures to improve health care quality at the pharmacy level. The founding members of the PQA include AHIP, the NACDS, the NCPA, the American Pharmacists Association (APhA), and representatives of pharmacy, consumer, and employer groups. CMS and the Agency for Healthcare Research and Quality (AHRQ) also will play a significant role in the PQA's work.

The mission of the PQA is to improve health care quality and patient safety through a collaborative process in which key stakeholders agree on a strategy for:

- measuring performance at the pharmacy and pharmacist levels;
- collecting data in the least burdensome way; and
- reporting meaningful information to consumers, pharmacists, employers, payers, and other health care decision-makers to help them make informed choices, improve outcomes and stimulate the development of new payment models.

The PQA's activities will be conducted primarily through a Quality Metrics Work Group and a Reporting Work Group. Health insurance plans are committed to playing a constructive role in the PQA's efforts to improve quality and reduce costs in the Part D program and throughout the U.S. health care system. This work will build upon steps we have taken during the initial implementation phase of the Part D program—in collaboration with pharmacy organizations and other partners—to improve beneficiary services and streamline processes at the pharmacy level.

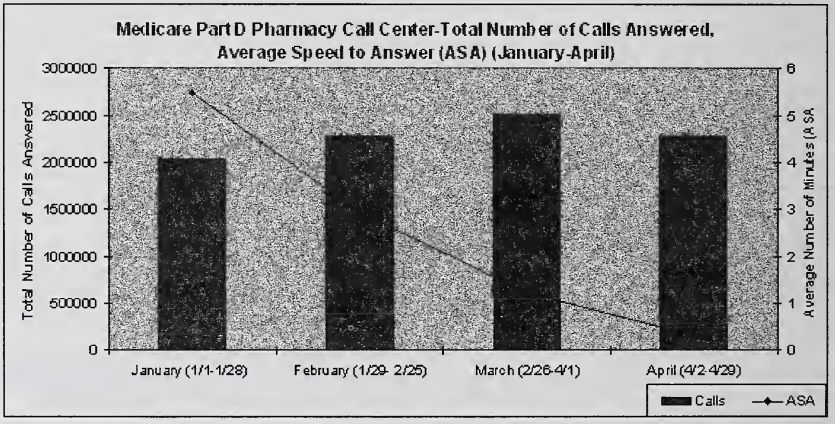
Increasing Capacity for Customer Call Centers

In response to the systems issues that surfaced in the early weeks of the Part D program, plan sponsors moved quickly to increase the number of customer service representatives who are available to handle the high volume of phone calls—from both beneficiaries and pharmacists—that were generated by these unanticipated issues. At the same time, plans extended the hours of their customer service lines

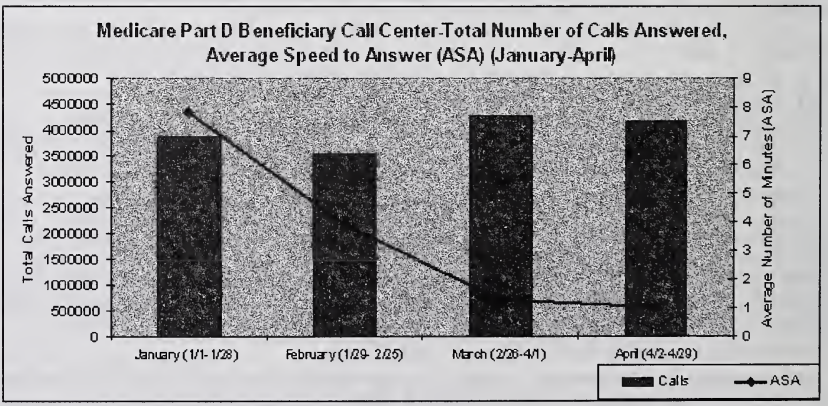
and provided representatives with specialized training to make every possible effort to ensure that beneficiary questions are answered on a timely basis and that pharmacists have the information they need to promptly fill prescriptions for Part D enrollees.

AHIP has tracked the performance of plan call centers since the Part D program was implemented in January. Over the first four months of the program, the response time of plan call centers improved dramatically for both pharmacists and beneficiaries—even as call volumes continued at a high level. The following findings are based on data submitted by Part D sponsors covering approximately 12 million beneficiaries.

- *Pharmacy Call Centers:* The average speed-to-answer of plans' pharmacy call centers dropped from nearly 8 minutes during the first week of the program to under 30 seconds during the week of May 6. During the first four weeks of January, the average speed-to-answer was 5.5 minutes. As shown by the graphic below, plans improved this average speed-to-answer time to under 20 seconds during the first four weeks of April.



- *Beneficiary Call Centers:* The average speed-to-answer of plans' beneficiary call centers dropped from nearly 11 minutes during the first week of the program to under 2 minutes during the week of May 6. During the first four weeks of January, the average speed-to-answer was 7.8 minutes. As shown by the graphic below, plans improved this average speed-to-answer time to 1 minute during the first four weeks of April.



These data clearly show that plan sponsors have succeeded in significantly reducing wait times for beneficiaries and pharmacists by devoting additional resources to their call centers.

Improving the Presentation of Beneficiary Information

Over the past month, we have been hard at work developing an initiative that will reach out to beneficiaries, pharmacists, physicians, and other stakeholders to improve the presentation of information about beneficiary choices. We believe the Medicare Personal Plan Finder is the most versatile tool for helping individual beneficiaries assess their options and choose a plan. While many beneficiaries do not have direct access to this online resource, their family members and state health insurance program counselors often are able to use the Plan Finder to show them comparative information on cost, coverage, formularies, and pharmacy access for plans in their area. We believe the Plan Finder could be accompanied by a simple "Beneficiary Guide" that walks consumers through the process of selecting the Part D plan that will best meet their needs—aligning their current coverage, prescription history, and other considerations with the plans available in their community.

In the coming weeks, AHIP will be pursuing a broad partnership to take further steps toward accomplishing these goals in a clear and user-friendly format. It also is critical that adequate funding be provided for the Medicare Personal Plan Finder and for the outreach and education efforts that support beneficiary decision-making under the Part D program.

Supporting Advocacy by Beneficiary Groups for Flexible Surrogate Decision-Making

Working with AHIP's Beneficiary Issues Advisory Group, plan sponsors are focused on eliminating burdensome documentation requirements for family members who are acting on behalf of Medicare beneficiaries in states that have enacted a streamlined approach to surrogate decision-making.

AHIP recently sent a letter to CMS, urging the agency to clarify that persons who are considered "surrogate decision makers" under state laws can act on behalf of cognitively impaired or incapacitated beneficiaries to make enrollment or disenrollment decisions under the Part D program. AHIP also provided the agency with suggested language, based on discussions with beneficiary advocates, for revising the relevant guidance manuals. This recommendation, which CMS is taking steps to implement, will help to protect the interests of beneficiaries who cannot make health care decisions for themselves.

III. PART D IS PROVIDING VALUE TO BENEFICIARIES AND TAXPAYERS

Part D sponsors are exceeding expectations. This outcome is largely a result of the fact that plans have developed a number of tools and techniques that have proven to be highly effective in making prescription drugs more affordable for consumers. This positive outcome is also a result of the success of the MMA legislation in creating strong and vibrant competition among health plans, leading to lower costs and better benefits for Medicare beneficiaries.

The value offered by Part D plans can be seen in the lower-than-expected premiums that beneficiaries are paying. Before plans submitted their benefit packages for 2006, beneficiary premiums were projected to average $37 a month. However, according to CMS,[1] the average premium that beneficiaries are paying for prescription drug plans nationwide is actually $23 a month—approximately 38 percent lower than originally expected—with a number of plans offering premiums that are far lower.

In addition, many plans have deductibles below the $250 maximum standard, including 58 percent of all stand-alone prescription drug plans that offer zero deductibles[2] According to CMS,[3] 69 percent of beneficiaries in stand-alone prescription drug plans and 89 percent of beneficiaries in MA–PD plans have selected options offering zero deductibles.

All across the nation, plans are giving beneficiaries the option of choosing prescription drug coverage that goes well beyond the minimum requirements established by the MMA. Many plans are providing additional benefits in the MMA-established "coverage gap" that begins after a beneficiary's annual drug expenditures exceed $2,250. Under the MMA, the standard benefit includes a coverage gap in which beneficiaries would pay 100 percent of their total drug costs exceeding $2,250 until their out-of-pocket expenditures reach $3,600. However, in all 50 states, beneficiaries have the option of choosing a Part D plan that covers a portion of the costs in this coverage gap. These added benefits in the coverage gap are offered by 15

[2] AHIP analysis of CMS data, November 2005

[3] CMS, Presentation by Abby Block, Director of Centers for Beneficiary Choices, April 5, 2006

percent[4] of stand-alone Part D plans and 25 percent[5] of Medicare Advantage plans with prescription drug coverage.

The vast majority of beneficiaries have responded to these choices by selecting benefit packages that differ from the minimum requirements set by the MMA. CMS data[6] show that the standard defined benefit has been selected by only 16 percent of beneficiaries in stand-alone prescription drug plans and by only 5 percent of beneficiaries in Medicare Advantage plans with prescription drug benefits (MA–PD plans). All other beneficiaries are choosing plans that offer enhanced benefits or alternatives to the standard benefit.

Savings Generated by Competition

Overall, HHS has reported[7] that beneficiaries who previously did not have drug coverage are now saving an average of $1,100 on their annual prescription drug costs by enrolling in the Part D program. Moreover, a recent CMS analysis[8] found that beneficiaries who select the lowest-cost plan in their area can save up to 71 percent relative to the amount they would pay without prescription drug coverage.

While all types of beneficiaries can save money by choosing Part D plans, financially vulnerable beneficiaries can expect to receive exceptionally large savings because of the low-income subsidies the MMA provides. On average, Medicare will pay more than 95 percent of prescription drug costs for these low-income beneficiaries.

The savings available to low-income beneficiaries are measured by an August 2005 study, performed by PricewaterhouseCoopers,[9] which concluded that beneficiaries with incomes at or below 150 percent of the federal poverty level and who are not on Medicaid can expect to see their annual out-of-pocket prescription costs drop from an average of $1,657 to $180 by participating in the new drug program. Another more recent study, conducted by the Lewin Group,[10] found that beneficiaries without previous drug coverage who have one or more of five chronic conditions—arthritis, diabetes, hypertension, osteoporosis, or respiratory illness—can save 58 percent on their drug costs by enrolling in a Part D plan.

Taxpayers also are benefiting from plans' success in delivering quality prescription drug coverage at an affordable price. HHS has announced[11] that the savings generated by competition in the Part D program are greater than expected and are reducing costs for Medicare. Since July 2005, the projected cost of the Part D program for 2006 has declined by $7.6 billion. Similarly, projected program costs for the next five years have declined by $30 billion according to HHS' most recent estimates. These lower-than-expected costs mean that taxpayers are receiving high value for the dollars they invest in the Part D program.

Tools and Techniques for Increasing Value

The prescription drug benefit is a major step toward modernizing Medicare. In recent decades, prescription drugs have played a larger and larger role in health care treatment, significantly improving the management of chronic conditions and helping to keep people healthier. These benefits, taken for granted by many who have employer-based health coverage, are now a universal part of Medicare, thanks to the new Part D program.

Because prescription drugs are now more affordable for more Medicare beneficiaries than ever before, we are likely to see improved compliance with prescription drug regimens. This development will support the ongoing efforts of health plans and providers, working with CMS, to achieve better health care outcomes. Vulnerable and high cost populations, such as those who are dually eligible for Medicare and Medicaid and those with chronic conditions, are logical starting points for improved coordination of care, better use of integrated data, and a renewed focus on performance and outcomes. Health plans are using the new Special Needs Program to provide targeted services to beneficiaries who are dually eligible, institutionalized, or living with chronic conditions. Further, as a result of the MMA, some of

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[4] Kaiser Family Foundation, Percent of Medicare Prescription Drug Plans (PDPs) Offering Coverage in the Benefit Gap, 2006

[5] Medicare Payment Advisory Commission, March 9, 2006 briefing

[6] CMS, Presentation by Abby Block, Director of Centers for Beneficiary Choices, April 5, 2006

[7] HHS, Secretary's Progress Report II on the Medicare Prescription Drug Benefit, February 22, 2006

[8] CMS Office of Policy, Analysis of Savings Available Under Medicare Prescription Drug Plans, March 1, 2006

[9] PricewaterhouseCoopers, Medicare Tomorrow: Future Savings for Beneficiaries, August 25, 2005

[10] The Lewin Group, Chronic Health Conditions & the New Medicare Part D Benefit: Savings on Frequently Used Medications, April 12, 2006

[11] HHS, Secretary's Progress Report II on the Medicare Prescription Drug Benefit, February 22, 2006

these health plans are working with states to provide integrated coverage of Medicare and Medicaid services through a single health plan.

AHIP's members are able to offer high quality, affordable coverage through the Part D program because they have developed tools and techniques to reduce out-of-pocket costs for beneficiaries and, at the same time, improve quality by reducing medication errors and promoting clinically sound drug use.

Drug Interactions: Before Part D, if a Medicare beneficiary purchased drugs at more than one retail location, or perhaps via the mail, no one entity had a complete picture of all the drugs that he or she was taking. Now, through their pharmacy benefit manager, plans are able to review all the drugs that an individual is taking and identify potentially dangerous interactions before the drug is dispensed to the member. Likewise, plans are also able to monitor dosages and frequently abused drugs, like narcotics, and assure that they are treated appropriately.

Encouraging Generic Drug Use: An important steps Medicare beneficiaries can take to minimize their drug costs, and in many cases avoid the coverage gap, is to utilize generic drugs, which cost on average less than 20 percent of their brand counterparts. Many plans encourage this by designing products with reduced co-pays for generic drugs. In addition to keeping plan premiums low, this approach minimizes the cost to the beneficiary and makes the most of the coverage that Medicare Part D provides.

Formularies: Formularies, which also play an important role in controlling costs, must comply with stringent standards to ensure that they include drugs necessary to treat all major diseases. Medical professionals play a central role in developing formularies. To ensure that formulary decisions are clinically appropriate,health plan Pharmacy & Therapeutics Committees—comprised principally of physicians and pharmacists—identify drugs for inclusion on health plan formularies based on documented safety, efficacy, and therapeutic benefit.

A number of studies demonstrate that these strategies are highly effective in making prescription drugs more affordable for consumers. For example:

- The Congressional Budget Office (CBO) has estimated[12] that private sector management techniques employed by Medicare Part D plans would save individuals 20–25 percent off retail prices for prescription drugs.
- A 2003 study,[13] conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania—the largest state pharmacy assistance program in the nation—could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.
- In addition, the Government Accountability Office (GAO) has reported[14] that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings clearly demonstrate that the private sector has a strong track record of using its experience and capabilities to deliver affordable prescription drug benefits. At a time when federal resources are severely strained, it is important for policymakers to recognize the ability of health insurance plans to implement strategies that are enabling Medicare beneficiaries to receive the greatest possible value for the dollars the Medicare program is spending on their prescription drug coverage.

IV. BENEFICIARY EXPERIENCES AND ATTITUDES

Numerous surveys show that a large percentage of the overall Medicare population is pleased with the new program and the benefits it is delivering.

In early March, Ayres, McHenry & Associates conducted two surveys to evaluate the attitudes of beneficiaries who already were covered by Part D plans. One survey[15] focused on beneficiaries who chose plans on their own and the other focused on dual eligibles who were automatically enrolled in the program. Among seniors who voluntarily signed up for the program, 59 percent said they already were saving money and more than 80 percent reported that they had no problems related to enrollment or usage of their new benefits. Additionally, 65 percent of enrolled seniors

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[12] CBO, A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit, July 2004

[13] Associates & Wilson, Prescription Drug Benefit Management: Improving Quality, Promoting Better Access and Reducing Cost, October 2003

[14] Government Accountability Office, Federal Employees' Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies (GAO–03–196), January 2003

[15] AHIP, Most Medicare Drug Enrollees Already Saving, March 13, 2006

said they would recommend that other seniors sign up for the program, versus 8 percent who said they would not.

The other survey[16] by Ayres, McHenry & Associates found that among seniors who are dually eligible for both Medicare and Medicaid, 90 percent said they had experienced no problems using the new Medicare drug benefit. Another 4 percent said they had a problem that was resolved, while 4 percent said they had a problem that was not yet resolved.

In the intervening months, these findings have been reinforced by numerous other surveys indicating that beneficiaries are well-served by the Part D program:

- The Medicare Rx Education Network released a survey,[17] conducted by KRC Research, which found that among beneficiaries who are enrolled in stand-alone Part D plans, 87 percent report that the new drug benefit is working well for them.
- The U.S. Chamber of Commerce released a survey,[18] conducted by The Tarrance Group, showing that 84 percent of Medicare Part D enrollees are satisfied with their drug coverage and 52 percent say they are receiving significant cost savings. This same survey found that 91 percent of Part D enrollees say their plan is convenient to use at the pharmacy and 77 percent say they would recommend their plan to others.
- Medicare Today released a survey,[19] conducted by American Viewpoint, indicating that 73 percent of persons already covered under the Part D program found the enrollment process to be "very easy" or "relatively easy." Among beneficiaries who already have tried to use the new benefit, 86 percent reported that they experienced no difficulties in obtaining their prescriptions.
- An ABC News/*Washington Post* survey found that 74 percent of Part D enrollees had an easy time enrolling in the program and that 63 percent are saving money through the program.

V. CONCLUSION

We appreciate this opportunity to testify about our members' experiences and their strong commitment to the long-term success of the Medicare Part D prescription drug program. We appreciate the support many members of the committee have demonstrated for this valuable program and for a strong public-private partnership in Medicare. We look forward to continuing to work with you on these important issues.

Appendix A

Statement by the Board of Directors of America's Health Insurance Plans on Maximizing Quality and Affordability of Prescription Drug Coverage for Medicare Beneficiaries

April 27, 2006

INTRODUCTION

Formularies and other pharmacy benefit management strategies allow Part D plans to control costs while ensuring the quality and safety of prescribed drugs for Medicare beneficiaries. These tools have kept Part D premiums affordable for beneficiaries and reduced costs to the federal government. Beneficiaries, who were initially expected to pay $38 per month in Part D premiums, are paying an average of $25. This is a savings of nearly one-third of the predicted premium amount, and the projected cost of the program to the federal government has been reduced by $7.6 billion in 2006 and $30 billion over the next five years. For this success to continue, Part D plans need to rely on the proven best practices in pharmacy benefit management that are already providing Medicare beneficiaries with affordable, high-quality prescription drug benefits.

The formulary is a list of drugs that have been reviewed for safety and efficacy and are approved for coverage by the plan. Such drugs commonly are categorized into several "tiers," with cost-sharing for the drug determined by the tier to which

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[16] AHIP, Ninety Percent of Low-Income Seniors Surveyed Say No Problems Using Medicare Drug Benefit, March 13, 2006

[17] Medicare Rx Education Network, Survey Assesses New Medicare Drug Program, April 3, 2006

[18] U.S. Chamber of Commerce, *Nationwide Poll of Seniors Shows High Level of Satisfaction With Medicare Prescription Drug Plan,* April 25, 2006

[19] Medicare Today, New Poll: Seniors Find Enrollment Less Complicated Than They Expected, April 12, 2006

it is assigned. Formularies play an integral role in ensuring beneficiaries have cost-effective access to clinically appropriate drugs. Part D plans have Pharmacy and Therapeutics (P&T) Committees, primarily composed of physicians and pharmacists that make decisions about which drugs to include on formularies based upon a clinical review of the scientific evidence. Formularies promote affordability by encouraging competition among pharmaceutical manufacturers. Once the P&T Committee determines there are multiple drug products with similar therapeutic value, they consider cost effectiveness to ensure that beneficiaries receive the greatest value from their prescription drug benefit.

The Centers for Medicare & Medicaid Services (CMS) evaluates and approves all Medicare Part D formularies to ensure they are comprehensive in accordance with CMS standards. CMS has established clear procedures under which beneficiaries and their physicians can request coverage of prescription drugs that are not on a plan's formulary. This process establishes strict timeframes and includes an opportunity to appeal to external reviewers who have no affiliation with the plan.

ENSURING CONTINUITY FOR BENEFICIARIES

In addition to premiums and out-of-pocket costs, the drugs included on a Part D plan's formulary and the tier structure are important factors that Medicare beneficiaries evaluate when determining which Part D plan best meets their specific needs and circumstances.

Appropriate formulary management improves clinical benefits and reduces costs for Medicare beneficiaries. The prescription drug arena is continuously evolving, with new scientific evidence emerging almost daily regarding the efficacy of various medication therapies, side effects and adverse reactions of both newer and older medications, interactions among medications, and disease specific concerns. With that in mind, Plan sponsors may need to make formulary changes during the year to provide Medicare beneficiaries with a prescription drug benefit that reflects the latest in scientific evidence.

At the same time, AHIP members strongly support maintaining continuity of care if a formulary change is made. Accordingly, we will support CMS' efforts to ensure that Medicare beneficiaries who have been prescribed a covered Part D formulary medication will not be required to change their medication or pay increased copayments or coinsurances throughout a contract year except when:

- Safety or efficacy concerns have been identified by the Food and Drug Administration and/or the plan's Pharmacy and Therapeutics (P&T) Committee based upon scientific evidence; or
- An FDA approved generic alternative to a brand name drug becomes available.

In these two circumstances, changes for existing enrollees are justified to protect the health of beneficiaries or enable them to receive greater value for the dollars they spend on prescription drugs while ensuring quality. Changes would only be made following appropriate notice as specified by CMS.

Appendix B

Statement by the Board of Directors of America's Health Insurance Plans on Maximizing Quality and Affordability of Prescription Drug Coverage for Medicare Beneficiaries

June 7, 2006

INTRODUCTION

Health insurance plans recognize the essential role pharmacists play in meeting the prescription drug needs of Medicare beneficiaries. To maintain effective working relationships with pharmacists, health plans are committed to establishing best practices for prompt payment to ensure that pharmacies are paid on a timely basis for "clean" claims. This priority is a key element of our comprehensive efforts to promote stability—and value for beneficiaries—in the Medicare Part D prescription drug program.

A typical pharmacy payment cycle includes a series of key steps, for example:

- While filling prescriptions for Part D enrollees, the pharmacy submits claims in real-time to the pharmacy benefit manager (PBM).
- The PBM consolidates "clean" claims every 15 days—and more frequently in some instances—and notifies the plan of the payment amount due. To fulfill responsibilities to the Medicare program to guard against possible fraud, an evaluation takes place to identify questionable claims for further investigation.

- The plan reviews the payment request(s) and either makes payment or authorizes payment from an account from which the PBM pays pharmacies on behalf of the plan.
- The PBM or plan promptly pays the pharmacies or designated pharmacy buying group via check or electronic funds transfer (EFT), and provides remittance advice. The PBM may consolidate the payments it receives from multiple payers before forwarding payment to the pharmacy or designated pharmacy buying group. In the case of a designated pharmacy buying group, the buying group distributes payments to individual pharmacies participating in the group.

BEST PRACTICES

To ensure that pharmacy payment processes work as efficiently and effectively as possible, health plans providing prescription drug coverage to Medicare beneficiaries are committed to supporting the following best practices:

- Plans will work with PBMs to ensure that payment for "clean" claims is transmitted via mail or EFT to pharmacies at least twice per month and that payment for all "clean" claims is transmitted via mail or EFT no later than 30 days after the claims are submitted by the pharmacy.
- Plans will work with PBMs and the pharmacy community to promote availability and utilization of EFT. Since maximum efficiency results from the combination of EFT and the transmittal and acceptance of electronic remittance advice, we will work collaboratively to promote use of both of these electronic transmittals.

Mrs. JOHNSON OF CONNECTICUT. Mr. Firman.

STATEMENT OF JAMES FIRMAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL COUNCIL ON AGING

Mr. FIRMAN. Good afternoon. My name is Jim Firman. I am the President and CEO of the National Council on Aging (NCOA), the Nation's first organization formed to represent America's seniors and those who serve them. NCOA, with some reluctance, supported the Medicare Modernization Act of 2003 (P.L. 108–173), primarily because of the generous extra help that it promised to provide to 14 million low-income seniors. We believe several aspects of the Part D program implementation have gone quite well, and we commend the efforts of CMS, SSA, Administration on Aging (AOA) and others who work closely with the private sector to achieve the results that we have achieved so far. We believe there is very important work that needs to be done, especially in the next period of time.

NCOA chairs the Access to Benefits Coalition which includes 104 diverse national organizations and 55 local coalitions dedicated to helping low-income beneficiaries to make optimal use of the Medicare drug benefit and other resources. Between July 2005 and March of 2006, ABC has helped over 90,000 people to apply for the LIS benefit and held more than 7,000 educational—over 7,000 events and provided over 260,000 individual counseling sessions; in addition, NCOA and ABC, led by the My Medicare Matters Program, a comprehensive community-based campaign to help people with Medicare and their families understand the new benefit, assess their personal situation, and make the choices that were best for them. Through this campaign, we conducted over 3,100 events, assisting more than 200,000 people to get coverage. Finally, we are also proud of our work through Benefits Checkup, an on-line Web site that helped 489,000 people over the last 15 months to figure out what benefits they are eligible for, and through that process we

identified 125,000 more people eligible for the LIS benefit. we have been in this very deeply on the ground, across the country, trying to help people.

Here are some of our conclusions and recommendations:

Despite the success so far, there is clearly a very important job to be done. CMS states that of the approximately 4 million beneficiaries without the drug coverage, approximately 3.2 million are eligible for and not receiving the low-income subsidy (LIS). In addition, we believe there is at least another million people who may have signed up for one of the plans who are also eligible for the LIS benefit, and we don't believe that is in the count we have been talking about so far.

Finally, our analysis of recent SSA data indicate there is probably at least another 150,000 people who applied to SSA in eight States and were denied coverage, who actually would be eligible had they been told that they could apply through the Medicare Secondary Payer (MSP) program. These States are Alabama, Arizona, Connecticut, Delaware, Maine, Mississippi, New York and Vermont. Those States do not have asset tests for the MSP program, so people who were denied by SSA in fact would have gotten the LIS benefit plus another $1,000 in Part B savings had they applied through MSP.

Clearly, LIS eligibles are in the greatest need of help and this has tremendous value for them. The promise and the potential of the Medical Modernization Act will not be realized until we find and enroll all of these people who are eligible for and not receiving any extra help. We applaud CMS for creating the special enrollment period for beneficiaries between now and the end of the year. However, it is imperative that there be significant effort directed to finding and enrolling these people during this time.

NCOA has developed a series of programmatic and legislative recommendations for reaching and enrolling these people. We would appreciate the Committee's support and recognition that it will require robust and sustained effort to find these people. We need to keep the heat on in order to achieve the result. We need a concerted effort not only among Federal agencies, but among the wide variety of private organizations, to work to the cost-effective and evidence-based strategy. Some of these strategies are as follows: We have learned, first of all, that using lists of those likely to be eligible is one of the most promising approaches; we are, essentially, if there are 3 million people defined, we are looking for 1 in 100 Americans in this country, you can't do that through broadcast. You have to do that through targeted list strategy where you can focus efforts and take the time to persuade people; Secondly, we need a person-centered approach using trusted intermediaries and Web-Based tools to provide one-on-one assistance to achieve the result. People need to be reached by people who they trust. They need to be persuaded, and then they need to be assisted with filling out the forms. Otherwise, it won't work. Continuous learning is also important, and, as assessed, we need benchmarking, testing, analyzing of what works. We shouldn't have to be listening to anecdotes. You should be listening to data for cost per enrollment of different strategies. It is possible to do that, and

you need that. Finally, we need to recognize this effort will take quite a long time to do this.

One more moment, if I can. I just want to point out NCOA is working with CMS right now and the Nonprofit Benefits Data Trust to use these strategies to identify LIS eligibles, and we are also working with Representatives to include a National Center for Senior Benefits Outreach and Enrollment in H.R. 5293 which would reauthorize the Older Americans Act.

I want to say that this problem of finding and enrolling the 3 or 4 million people is solvable. We now know enough about what needs to be done. We have an evidence debate about how to do it, and the only question is, will we have the will and the resources to get the job done? Thank you very much.

[The prepared statement of Mr. Firman follows:]

Statement of James Firman, President and Chief Executive Officer, National Council on Aging

Good morning. My name is James Firman and I am the President and CEO of The National Council on Aging (NCOA)—the nation's first organization formed to represent America's seniors and those who serve them. I also chair the Access to Benefits Coalition (ABC), a public-private partnership of over 100 diverse organizations dedicated to ensuring that lower income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. Thank you for inviting me to participate in today's hearing.

Founded in 1950, NCOA is a national network of organizations and individuals dedicated to improving the health and independence of older persons, increasing their continuing contributions to communities, society and future generations, and building caring communities. Our members include senior centers, area agencies on aging, faith-based service agencies, senior housing facilities, employment services, and consumer organizations. NCOA also includes a network of more than 15,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work.

As the Committee is aware, NCOA supported the Medicare Modernization Act. The primary reason for our support was the generous extra help provided to low-income beneficiaries in greatest need. We believe several major aspects of Part D program implementation to date have been quite successful—with approximately 90% of Medicare recipients now having coverage, providing choice to consumers, and containing plan costs. Much of NCOA's focus in promoting successful program implementation has been on the need to improve access to the benefit for low-income beneficiaries—who comprise an estimated 3 million of the approximately 4 million currently non-enrolled seniors who still do not have prescription drug coverage. We are also concerned about an additional one million or more beneficiaries who we believe are eligible for extra help and are enrolled in a Part D plan, but who are not receiving the LIS. As I will indicate later in this testimony, we have developed programmatic and legislative recommendations for reaching and enrolling vulnerable, low-income beneficiaries and we would appreciate the Committee's support and recognition that it will require a robust and sustained effort to effectively provide Part D benefits to the remaining beneficiaries who qualify for low income support. The promise and potential of the Medicare Modernization Act will not be realized until we find and enroll all of the people who are eligible for and not receiving the Extra Help available to them.

The Access to Benefits Coalition (ABC)

Founded in 2004, ABC members share an interest in helping millions of people with Medicare likely to be eligible for this extra help (including both those aged 65 and over as well as younger persons with disabilities who qualify) find the prescription savings they need to maintain their health and improve the quality of their lives. Chaired by NCOA, the Coalition has 104 national nonprofit organizations as members. These include aging and health care organizations such as AARP and the Catholic Health Association of the U.S., national charities such as Easter Seals, and groups representing patients and caregivers such as the Alzheimer's Association and the National Alliance for the Mentally Ill. In addition, faith-based and multi-cultural groups such as Catholic Charities USA and the National Alliance for Hispanic

Health are active members. A complete list of members is available on the Coalition's web site (www.accesstobenefits.org)

The national Coalition has involved hundreds of community-based nonprofits through 55 local coalitions in 35 states and the District of Columbia, in educating and enrolling tens of thousands of beneficiaries in the Extra Help and other prescription savings programs.

The Coalition and its network of local organizations use powerful Web-based tools such as NCOA's BenefitsCheckUpRx decision support tool (found at www.BenefitsCheckUpRx.org) and the Medicare Plan Finder (found at www.Medicare.gov) to help beneficiaries, as well as family caregivers and organizations who wish to assist them, understand, apply, and enroll in public and private prescription savings programs. BenefitsCheckUpRx also helps determine if they qualify for Medicare's Extra Help or other prescription savings programs and allows them to apply for these programs on line. Since January 2005, we screened more than 489,000 people using this service, including more than 125,000 people who were eligible for and not receiving Medicare's Extra Help.

Some of the on-line comments we have received from our web-based support tools include:

The website is awesome and extremely helpful. As a social worker, I refer families to your website on a daily basis! I have been using the site for several years now, and it is so easy to use and understand.

—Mandy D.

I just wanted to write and thank you for providing this great program online, for free, to the public. I am the sole person responsible for managing my mother's needs as she ages, and since she does not possess a fair command of English as an immigrant, she relies on me to find out information and help her execute administrative/legal matters. It would have taken me a lot longer to collect all of the program info together on my own, and I really appreciate that the resulting report is personalized to the individual's circumstances/needs.

—Genevieve L

"To the Angels at the other end,

For over three weeks, I have been phoning agency after agency trying to find out about help for my Mother. In less than half an hour, your site provided me with everything I could ask for. God bless you for compiling this information in one easy step."

—Karen T.

My husband is an insurance agent in a rural environment with many low-income clients. The advent of the new Medicare Part D has some of them very worried because their physicians have told them that they won't get low-income prescription drug assistance from the drug companies anymore because of Part D and yet they can't afford the health plans that are needed to help with their prescriptions. They don't know who else to ask, so they have begged my husband to assist them in finding help. We are so relieved that we found something to allow my husband (with no training in this area other than selling Part D and supplemental plans) to sit down with his low-income clients, walk them through the questionnaire and help them find agencies that will give them the assistance they so desperately need.

—Teresa E.

The goal of the Coalition is to educate and help Medicare beneficiaries with limited incomes to quickly and measurably make informed choices about Medicare prescription drug coverage and other prescription savings programs; and facilitate their actual enrollment in these programs through: (1) developing and using the best-available knowledge from the public and private sectors about best practices and the most cost-effective strategies for reaching and enrolling Medicare beneficiaries with limited means; (2) activating and supporting nationwide community education and outreach, focused on reducing confusion and providing beneficiary support in decision-making and enrollment; (3) developing and implementing a public information and outreach campaign; (4) developing a robust decision-support tool to help consumers make optimal choices; and (5) mobilizing widespread support and participation in national, state, and local ABCs.

During the nine months between July 2005 and March 2006, some of the accomplishments of the ABC include:

- Helping 90,000+ people submit applications for the low-income subsidy;
- Holding nearly 7,000 group education events and educating over 500,000 people at these events;
- Providing 265,000 individualized counseling sessions; and

- Enrolling 150,000+ LIS-eligible people in PDPs or MA–PDs.

After two years of work, the Coalition has learned a number of valuable lessons about outreach and enrollment strategies for Medicare beneficiaries with limited incomes that can be of use to the larger effort to encourage this population to apply for the Extra Help:

- Using lists of those most likely to be eligible is one of the most promising and scalable approaches.
- A person-centered approach using trusted intermediaries to provide one-on-one assistance and screen for multiple benefits enhances results.
- Coordination and division of labor among agencies in a given community or state can improve outreach and enrollment outcomes.
- Targeted, effective media can drive traffic to events and phone-based enrollment centers where beneficiaries can receive personalized assistance with applying for benefits.

The *My Medicare Matters* Campaign

My Medicare Matters (MMM) is a comprehensive, community-based educational initiative with a national presence designed to help people with Medicare and their families understand the new Medicare Prescription Drug benefit, assess their personal situation, understand their choices, compare plan options and make the enrollment decision that is right for their health and their financial situation. NCOA and ABC sponsored *My Medicare Matters,* with support from AstraZeneca Pharmaceuticals. The first phase of the campaign operated from November 2005 through May 15, 2006.

MMM was active continuously throughout the entire six-month Part D enrollment period. The campaign included local community based organizations in more than 40 metropolitan areas, who participated in more than 3,100 events from December 2005 through May 15, 2006, where more than 210,000 people sought assistance to get answers to their questions at local events.

Time and again, we were told by seniors and their families that the *My Medicare Matters* campaign provided independent, objective and unbiased information about prescription drug coverage. Seniors, and the organizations that help them, constantly praised the MMM campaign as a much needed, trusted information source.

MMM provided the ideal combination of tech and talk—sophisticated, yet easy to understand, information and education via laptop computers, and one-on-one support from educators who were part of the on-the-ground teams. The campaign had mobile vans that traveled within the communities bringing computers and wireless access to internet-based tools such as www.BenefitsCheckUpRx.org, www.ssa.gov, and www.Medicare.gov. Educators helped seniors and their caregivers, family and friends understand their options and take action if they were ready.

Wireless technology was critical to our ability to take the campaign to where seniors lived. We went to senior centers, assisted living facilities, recreation sites, malls, pharmacies, supermarkets, NASCAR races and health fairs. Having computers and educators on-site permitted us to access our web site, Medicare.gov and the SSA site for the low income subsidy application. Our wireless technology was good, but not always completely reliable. More often than we liked, we were challenged by signal strength and were sometimes in locations where we could not receive a strong signal or high speed internet connection.

In conjunction with the campaign, a new web site, www.MyMedicareMatters.org was created for use by people with Medicare, their family and friends, or professionals and organizations. The web site provides simple and easy to understand information about the new coverage, and access to the same tools that can be used to learn about Part D. People were also able to enroll online or request Extra Help from SSA. The web site is also available in Spanish (www.MiMedicareImporta.org).

The web site was developed and tested with consumers. What we found was that seniors wanted to learn about the benefit and that to most effectively do so, they needed to understand the benefit in a linear way; that is, step-by-step. Unlike younger internet users, who can easily navigate and follow links on a web page, seniors wanted to be able to read in entirety the information that was needed for understanding. We also found that "learning" and "acting" needed to be separate. Again, in comparison to younger web users, seniors needed to be educated about the benefits first, and then be directed to "action" steps. So, for example, a senior would work through the MMM "7 Simple Steps" to learn about the benefits and then decide to move on to more detailed learning, or to www.medicare.gov for plan comparison.

We learned that the physical presentation of the web page was also very important. Easily understood information, with large buttons and simple navigation was

critical. Even those seniors with computers at home needed to be exposed to the internet with an educator before they had a comfort level to explore the internet Part D sites at home themselves.

Visitors to the MMM web site reported overwhelmingly that they were able to make an informed decision after reviewing the material on the site. More than three-quarters of the visitors indicated that they would recommend the site to family and friends. The web site had 4.2 million hits; web traffic on May 15 was three times greater than previous average attendance. In addition, the change in media coverage and tone as we neared the May 15 deadline was significant and we saw a corresponding steady increase in participation at our events.

We are now developing plans for Phase II of the My Medicare Matters program which we expect to announce later next month.

Medicare Part D Priorities Over the Next Five Months

The Centers for Medicare and Medicaid Services (CMS), the Social Security Administration (SSA), and the Administration on Aging (AoA) have done a commendable job in their initial efforts to implement the Part D benefit in a short period of time. Many deserve credit for enrollment efforts that have resulted in over 90 percent of beneficiaries with Part D drug coverage or the equivalent. Although the initial enrollment period has ended, there is a great deal of work left to do to make the Part D program a success. **CMS has estimated that of the approximately 4 million beneficiaries left to enroll in Part D, up to 75% are eligible for the low-income subsidy (LIS).** These LIS eligible beneficiaries are in greatest need of help—the benefit has the greatest value for them, and they are least likely to have had any previous prescription drug coverage.

Recognizing that much more needs to be done, CMS created a Special Enrollment Period (SEP) which helps set the stage for a major national effort to increase LIS enrollments between now and the end of 2006. We commend CMS for its action to permit beneficiaries who are accepted into the low income subsidy after May 15 to select a Part D Plan during the SEP without experiencing a premium penalty. It is imperative that significant efforts be directed over the next five months (before marketing begins on October 15 for the general open enrollment period) at finding and enrolling these vulnerable, low-income seniors and people with disabilities.

It is also important to recognize and address the needs of three other groups of beneficiaries who are likely eligible but not receiving LIS benefits. First, eight states have established eligibility criteria for Medicare Savings Programs (QMBs, SLMBs, QI–1s), that do not include an asset test (AL, AZ, DE, ME, MS, and VT for all 3 categories; CT and NY for QI–1s only). MSP eligible beneficiaries are deemed eligible for LIS. According to our analysis, more than 150,000 people in these eight states who applied to SSA and who were denied LIS coverage are actually eligible to receive LIS on the basis of their eligibility for MSPs.[1] However, they probably were not told about their eligibility for MSPs and therefore are unlike to be receiving both MSP and LIS benefits. We believe that use of sophisticated, web-based decision support tools, such as those described below, can help this population.

Second, we believe that there may be one million or more LIS-eligibles enrolled in PDPs and MA–PDPs who never attempted to enroll in the LIS either because they did not know about the benefit or did not think they would qualify. Plan sponsors should be strongly encouraged or required to perform targeted outreach based on demographic and transactional data available to them. Finally, we should bear in mind that about 60,000 new Medicare beneficiaries become eligible for the program each month and many of them have limited incomes.

Low-income seniors are historically difficult to reach. Studies show that even after 40 years, large percentages of low-income seniors eligible for important public benefits are not receiving them. Only an estimated 30% of seniors eligible for food stamps, 33% of people eligible for Qualified Medicare Beneficiary (QMB) protections, 13% of those eligible for Specified Low-Income Medicare Beneficiary (SLMB) protections, and 53% of the elderly eligible for Supplemental Security Income (SSI) actually receive the assistance for which they are entitled. Many LIS-eligible people do not believe they qualify, do not understand the value of the benefit and/or need one-on-one assistance with filling out the application forms.

NCOA is continuing to work aggressively during the SEP to find and enroll seniors with limited resources. To be successful, we need to engage in a concerted effort

[1] The figure is based on SSA data on the number of people who were denied coverage in the eight states that have no asset limits for at least one of the MSP programs. We then applied SSA's figure that 57% of all denials were for people who met the income limits, but not the asset limits.

among CMS, SSA and interested private organizations and target funding to the most cost effective, evidence-based strategies.

In 2005, ABC and the Bridgespan Group published a report entitled *"Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Income" (http://www.accesstobenefits.org/library/pdf/ABC%20ReportFNL62305.pdf). This benchmarking study presents the best practices and lessons learned for enrolling low-income people in available benefits programs:*

- Some of the key factors for reducing costs and increasing success include:
  - Well-executed phone-based enrollment
  - Use of technology such as online eligibility tools and wireless Internet access
  - Careful planning of the method, frequency and format of contact
  - "Qualifying" leads by identifying those most likely to be eligible before beginning the enrollment process
  - A steady volume of qualified leads matched with an organization's capacity
- The use of lists of likely eligible beneficiaries for targeted outreach and enrollment efforts is among the most promising, cost-effective and scalable approaches, and is necessary to maximize enrollment.
- A "person-centered" approach using trusted intermediaries to provide one-on-one assistance and screening for multiple benefits enhances results.
- Continuous learning is critical, both from one's own efforts, by testing, analyzing and refining the approach, and from best practices across projects.
- Government policies and practices that make it easier for consumers to apply for benefits have a large impact on enrollment success.
- Reaching full, or almost full, LIS enrollment will likely require significant resources, millions of hours of one-on-one assistance to potential beneficiaries, and several years to accomplish.

According to the Bridgespan study, "an examination of the scalability of various strategies indicates that list strategies are critical to an overall national strategy, not only because they can reduce the per capita costs of finding and enrolling beneficiaries, but because *this may be the only strategy that will enable groups to identify and connect with individuals who don't participate in community activities and don't respond to mass mailings."* (emphasis added).

NCOA has taken these findings seriously and has engaged in a number of initiatives in response to the recommendations. For example, NCOA is working closely with the Benefits Data Trust (BDT) using list strategies to identify likely eligible LIS beneficiaries and drive them to a national call center and local ABC's for LIS screening. BDT is a 501(c)(3) organization created to help eliminate poverty for seniors by enrolling them in benefits for which they are eligible. BDT maximizes private sector credit card initiatives, including direct-mail tactics and business-based one-on-one communication methods to identify, contact and help low-income beneficiaries apply for the LIS. Cost effective, sophisticated list strategies enable precise targeting, so that trusted local intermediaries with strong technical support can work from lists in which an estimated 4 out of 5 people are likely LIS eligible. CMS is contributing greatly to the success of these efforts through a research partnership with NCOA and BDT which enables us to "de-dupe" lists of people who are already enrolled in LIS. Over the next several months, BDT plans to conduct more than 400 different tests designed to identify the optimal strategies for reaching and enrolling various sub-populations of low-income Medicare beneficiaries.

NCOA has also worked closely with Representatives Tiberi and McKeon to include a National Center on Senior Benefits Outreach and Enrollment in H.R. 5293, the "Senior Independence Act of 2006," which would reauthorize the Older Americans Act. We applaud the efforts of these leaders and are hopeful that the House will pass the bill, which has strong bipartisan support, this month. The Center would provide technical assistance and support for benefits enrollment assistance and outreach to support efforts to inform and enroll limited income older individuals who may be eligible to participate, but who are not participating, in federal and state programs for which they are eligible, including: (1) maintaining and updating web-based decision support and enrollment tools and integrated, person-centered systems; (2) utilizing cost effective strategies to find and enroll those with greatest economic need; (3) supporting efforts for community-based organizations and coalitions to serve as enrollment benefit centers; (4) developing and maintaining an information clearinghouse on best practices; and (5) providing training and technical assistance on the most effective outreach, screening, enrollment, and follow-up strategies.

All of these efforts are integral to a unified national LIS enrollment strategy which should:

- Include a coordinated private sector effort that that complements CMS, AoA and SSA efforts;
- Use evidence-based and scalable practices;
- Work with and support trusted grass-roots organizations;
- Use sophisticated list strategies;
- Support specialty call centers (national and local) solely focused on LIS enrollments;
- Use sophisticated web-based enrollment tools;
- Build upon the success and learning to date; and
- Provide sufficient public and private sector funding to support the most cost effective, targeted, evidence-based approaches.

The Major Policy Barrier to Helping Low-Income Beneficiaries: The Asset Test

NCOA urges Congress to eliminate the asset test as a condition of LIS eligibility. According to SSA, of the people who have applied for the LIS and been rejected, the number one reason is the asset test. An estimated 57 percent of application rejections were due to excess assets.[2] According to a published report by the Congressional Budget Office, an estimated 1.8 million of the 15.1 million Medicare beneficiaries with incomes below 150% of FPL will not qualify for the additional assistance because their assets exceed the amount currently allowable.[3]

Removing the asset test from LIS eligibility requirements would also significantly reduce administrative costs, as verifying assets is the most time consuming aspect of determining LIS eligibility. Many beneficiaries do not know how to answer the questions on assets or how to obtain the information requested. Many applicants require a good deal of assistance in understanding the asset requirement and then they need help in obtaining the requisite information.

The asset test penalizes retirees who did the right thing by creating a modest nest egg to try to have some security in their old age. People who manage to save a modest sum for retirement and still have very limited incomes should be encouraged and rewarded, not denied the extra help that they need. According to a study from the Kaiser Family Foundation by UCLA's Thomas Rice, the asset test penalizes savings, denies benefits to those who clearly need the extra help and may discourage many people who might qualify from even applying.[4] Though the asset test is meant to exclude people with substantial resources, the Kaiser study found that half of those excluded had savings of $35,000 or less—not a lot of money to last the rest of your life after turning 65. The study also found that almost half of those the test disqualifies are widows, since their income often significantly declines after their husband dies. But assets from the marriage often exclude widows from eligibility in the LIS, since the limits are far lower for a single person than a couple.

We recognize that eliminating the asset test will be expensive, and is not likely to happen in the short term. There are, however, other important administrative and regulatory reforms that can be implemented quickly to significantly reduce the asset test barrier. First, the question on the cash surrender value of a life insurance policy should be eliminated from the LIS application. This question is confusing and difficult for seniors and people with disabilities to answer. Through our ABC coalitions we have heard a good deal of support to eliminate this question from the LIS application. Seniors and people with disabilities often plan to use their life insurance benefit to pay for their final expenses—they are often not willing to cash in their life insurance now and place an additional burden on their family members upon their death.

Second, SSA should not consider a 401k as an asset for purposes of determining LIS eligibility if a person is not drawing on the 401k. SSA should only consider a 401k when determining LIS eligibility if a person is drawing income from the 401k, and then only count the income.

Third, the LIS application should be reworked to provide further instruction and clarity with regard to the questions on jointly owned assets. The LIS application should provide space for applicants to explain why certain assets may be exempt. Assets that cannot be converted to cash within 20 days are not counted. The application as currently written requires applicants to include the value of these assets, but provides no space for them to rebut the presumption that the assets should be

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[2] Kaiser Family Foundation, "Medicare Prescription Drug Coverage Enrollment Update." May 2006.

[3] http://www.cbo.gov/ftpdocs/48xx/doc4814/11-20-MedicareLetter2.pdf

[4] Rice, Thomas and Desmond, Katherine "Low-Income Subsidies for the Medicare Prescription Drug Benefit: The Impact of the Asset Test." The Henry J. Kaiser Family Foundation, April 2005.

counted. As a result, applicants with assets that cannot be converted to cash are denied eligibility for LIS and must then file an appeal so they can provide their explanation. Time and resources would be saved for both applicants and SSA if applicants could provide the explanation at the time of their application.

Additional Medicare Part D Reforms

As Congress considers reforms for improving the Part D program, we urge that the following additional recommendations receive consideration, all of which would help low-income beneficiaries:

Indexing benefits—For the vast majority of beneficiaries, the value of the Part D benefit will decline over time, because their benefits are indexed to Part D drug costs, which will be particularly problematic for poorer beneficiaries with limited incomes. NCOA urges that Part D copayments and deductibles for people between 100 and 150% of the Federal poverty level be indexed to the Consumer Price Index (CPI), as the CPI is more reflective of cost increases and therefore more closely mirrors beneficiaries' ability to pay. For low-income people below 100% of the Federal Poverty Level, their prescription drug costs are increased according to the CPI.[5] Social Security implemented a cost-of-living increase of 4.1% in 2005[6] which corresponded to the CPI increase in that same year. However, for low-income subsidy eligible beneficiaries with incomes between 100–150% of poverty, Part D copayments are increased by the percentage increase in the annual average price of prescription drugs.[7] Historically, prescription drug costs increase at a rate of about 3 times higher than the rate of general inflation. Therefore, the benefit will become much less affordable over time.

Exceptions and Appeals—We have serious concerns that the current Part D exceptions and appeals process is not "consumer friendly" and should be fixed. A standard process should be created for all plans. Physicians should be permitted to file for exceptions on behalf of their patients. Systems should be designed to enable beneficiaries to file for an exception at the pharmacy at the time coverage is denied. Strong oversight is also needed to track and collect data on consumer experience with the exceptions and appeals process.

LIS In-Kind Support and Maintenance—The LIS application question on in-kind support and maintenance (ISM) should also be deleted. Because of beneficiaries' need to pay for their high prescription drug costs they often have to rely on ISM to make ends meet each month. For many seniors and people with disabilities their dependence on in-kind support would end if they were eligible for assistance with their prescriptions from the LIS. ISM includes the market value of food, room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection fees. It is unreasonable to expect applicants to know how to calculate the fair market valuation of many of these items, particularly sewerage and garbage collection services. This unrealistic level of detail may be resulting in potentially eligible beneficiaries not filing LIS applications.

Benefit standardization—We are concerned that many beneficiaries were confused by the broad range of benefit packages available to them. Too many choices made plan selection a difficult proposition, particularly for those without access to the internet. We therefore support the creation of a process not unlike the one that resulted in the development of 10 standard Medigap plans in the early 1990s. Representative Pomeroy was directly involved in the inclusive, successful Medigap process from his previous leadership in the National Association of Insurance Commissioners and can provide guidance on how such a process might work for Medicare prescription drug coverage.

Free PAP drugs in the coverage gap—For many years, Medicare beneficiaries without prescription drug insurance coverage have received prescription drugs free or at nominal cost through more than 150 Patient Assistance Programs (PAPs) sponsored by pharmaceutical companies. In 2003, those programs helped 6.2 million uninsured or underinsured patients obtain more than 17.8 million prescriptions. Many of the programs gave free prescription drugs to patients with incomes up to 200% of poverty and higher, with no asset restrictions, thus serving many needy low-income beneficiaries not eligible for LIS. In our view, positive incentives should be created for companies to provide this help. Congress should permit PAPs to provide free drugs in the coverage gap, or "doughnut hole," and count an agreed upon amount toward the True Out-of-Pocket (TrOOP) limits.

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[5] See § 1860D–14(a)(4) of the Social Security Act

[6] SSA Cost of Living is generally equivalent to the Consumer Price Index for Urban Wages Earners and Clerical Workers (CPI–W). http://www.ssa.gov/OACT/COLA/colaseries.html (Accessed June 6, 2006).

[7] See § 1860D–2(b)(6) of the Social Security Act.

Eligibility for other means-tested programs—When a person becomes eligible for the Part D low-income subsidy, the assistance they receive in paying for their needed prescription drugs should not be counted towards eligibility for, or the level of benefits received from, other needs-based programs. Some beneficiaries indicated that they did not enroll in LIS due to this fear. We should not diminish the value of the LIS benefit by allowing reductions to be made to other needs based programs an applicant may be receiving due to the LIS benefit. Congress should ensure that beneficiaries do not lose other needs based benefits, such as food stamps and Section 8 housing, due to the receipt of LIS benefits.

Conclusion

Through our efforts with the Access to Benefits Coalition and *My Medicare Matters* campaign, NCOA has been at the forefront of helping beneficiaries understand, navigate, and enroll in the new Medicare prescription drug benefit. While the program has had many successes, we remain concerned that millions of low-income beneficiaries in greatest need still are not receiving the help they are eligible for. We have developed programmatic and legislative recommendations for reaching and enrolling these vulnerable, low-income beneficiaries and we would appreciate the Committee's support and recognition that it will require a robust and sustained effort to effectively provide Part D benefits to the remaining beneficiaries who qualify for low income support. The promise and potential of the Medicare Modernization Act will not be realized until we find and enroll all of the people who are eligible for and not receiving the Extra Help available to them. NCOA looks forward to working with members of this Committee to make this a reality.

Mrs. JOHNSON OF CONNECTICUT. Mr. Gomez.

STATEMENT OF JORGE GOMEZ, CHAIR, SENIOR ISSUES TASK FORCE, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, KANSAS CITY, MISSOURI

Mr. GOMEZ. My name is Jorge Gomez, Commissioner of the Wisconsin Office of the Commissioner of Insurance. I am here today as Chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners. Let me begin by saying I commend Congress for the Medicare Part D program and CMS staff for implementing this program in such a short time. I also acknowledge the SHIP counselors and other consumer advocates for their tireless efforts in helping Medicare recipients understand their options.

As an organization, we believe Medicare Part D is a valuable program that needs to be successful. With that said, there are several critical issues that must be addressed. State regulators share complaints every day from Part D consumers and we urge Congress and the administration to work with us in resolving these lingering problems. The primary issue regards the general requirement that PDPs be licensed by the States as risk-bearing entities. Unfortunately, CMS ignored its own regulations in granting special waivers. According to the final CMS rule, a waiver from the State licensure may be granted if the PDP's sponsor submitted a fully completed application for licensure to the State. Instead, CMS granted waivers to PDP sponsors who did not comply with this requirement. This means that States and CMS have little information about the financial condition, the background of the owners, or the operations of those PDPs.

We understand that CMS has waiver applications from three more PDP sponsors from 2007 and we urge Congress and the administration to ensure that PDP sponsors have fully completed applications for licensure submitted before a waiver can be granted

as is required by Federal law. State regulators are also concerned about aggressive marketing practices. Certain brokers and agents have used Medicare Part D as a pretext to get in the door of Medicare eligible consumers. They then sell a variety of unrelated and sometimes unsuitable insurance products to these beneficiaries. State regulators want to clamp down on the cross-selling of non-Medicare products, but CMS marketing guidelines allow such sales activities. Other marketing issues include Medicare beneficiaries who have been placed in Medicare Advantage policies without their knowledge when they thought they were signing up for a PDP, or PDP sponsors selling from kiosks near pharmacies in large retail stores.

Stolen applications and computer leaks have exposed Medicare benefit claims to possible identity theft, which raises serious concerns about the carriers' processes and procedures. PDP sponsors must be required to dedicate sufficient resources to ensure compliance with applicable laws and company rules. State laws generally require agencies and brokers to be employed by an insurance company, thus ensuring more oversight and responsibility by the carrier. However, CMS challenges State authority from time to time to require agents who sell PDP products to be appointed by PDP sponsor. This weakens the ability of regulators to hold the PDP sponsor accountable for the actions of its agents and brokers who are selling their products.

One of the most frustrating elements of the Medicare Part D program is the limited ability of State regulators to directly assist consumers. The preemption of State authority over most operations of PDP sponsors means consumers must go to CMS for assistance. However, State regulators have a closer connection to their citizens, more dedicated resources, and greater expertise in dealing with consumer complaints. In particular, the NAIC is working with CMS to develop a formal process for sharing complaint information regarding the activities of PDP sponsors, agents, and brokers. We are hopeful this will improve our ability to protect and assist consumers and our individual markets.

There are large numbers of available Part D plans which have different formularies, cost sharing provisions and premiums. As this program evolves, we encourage Congress and the Administration to consider simplifying the program while maintaining adequate consumer choice. To mitigate problems beneficiaries may have in selecting an appropriate Part D program, the NAIC supports the expansion of the initial enrollment period through the end of 2006. This will provide Medicare beneficiaries sufficient time to consider their options and make the right enrollment choices without penalty. This extension would also allow beneficiaries who have mistakenly enrolled in one plan to switch to an appropriate plan without penalty. Finally, the NAIC also encourages Congress to increase SHIP funding to $43 million per year. SHIPs provide crucial education, counseling and outreach services to Medicare beneficiaries throughout the country and they are in all our States.

In conclusion, the NAIC would recommend the following to remedy some of these issues: Require a PDP sponsor to submit a fully completed application in a State before a special waiver is granted; support State laws requiring the appointment of the agent to in-

crease oversight of their marketing practices; develop specific guidelines limiting the cross-selling of insurance products to Medicare supplement and Medicare policies. Consider dialog with the NAIC on simplification on the Part D program; extend the open enrollment period of the program through 2006; and increase funding for the SHIPs.

Again, thank you for this opportunity, and I look forward to working with you and continued dialog with the future.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much.

[The prepared statement of Mr. Gomez follows:]

Statement of Jorge Gomez, Chair, Senior Issues Task Force, National Association of Insurance Commissioners, Kansas City, MO

Introduction

Good morning Mister Chairman and members of the Committee. My name is Jorge Gomez, Commissioner of the Wisconsin Office of the Commissioner of Insurance. I am testifying today as chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The primary objective of insurance regulation is to protect consumers and promote healthy insurance markets, and it is with these goals in mind that I comment today on the implementation of the Medicare Part D program.

To begin, I would like to note that the Medicare Part D program has extended much-needed prescription drug coverage to millions of Medicare beneficiaries. I would like to applaud the staff of the Centers for Medicare and Medicaid Services (CMS) for its tremendous effort to implement this program in such a short time. The State Health Insurance Assistance Program (SHIP) counselors and other consumer advocates must also be acknowledged for their hard work in helping Medicare recipients understand their options.

While for many Medicare beneficiaries the transition to the new program has been relatively smooth, several problems have arisen during the roll out of the program, and they continue to this day. As I will discuss, there are several critical issues that must be addressed and corrected. State regulators, who are on the front lines of consumer protection, are receiving complaints every day from consumers and we urge Congress and the Administration to work with us to resolve the lingering problems.

Waivers from State Licensure

One of the more troubling implementation decisions by CMS was to ignore its own regulations regarding granting of special waivers. According to the final rule, issued by CMS January 28, 2005, a special three-year waiver from state licensure may be granted to a Prescription Drug Plan (PDP) sponsor only "upon demonstration that an applicant to become a PDP sponsor has submitted a *fully completed* [emphasis added] application for licensure to the state." *70 Fed. Reg. 4551, sec. 423.410(d)*

Instead, CMS has decided to grant waivers to PDP sponsors, two of which are selling products nationwide, which have not submitted a fully completed application in any state. In fact, one of those PDP sponsors recently sent a letter to several states notifying them that they would not submit an application for licensure until the end of 2007. This means there are PDP sponsors selling products to Medicare beneficiaries and the states, along with CMS, have little, if any, information about their financial condition, the background of their owners, or their operations.

The NAIC has been informed that applications for such a waiver have been received from three more PDP sponsors for 2007. We urge Congress and the Administration to ensure that PDP sponsors have a fully completed application for licensure submitted before a waiver can be granted, as required by federal regulation.

Marketing Practices

The aggressive, unethical and even fraudulent marketing practices of certain brokers and agents and PDP sponsors have harmed many Medicare beneficiaries to date.

There are brokers and agents using Medicare Part D as a pretext to inappropriately get in the doors of Medicare-eligible consumers, then selling them a variety of unrelated and sometimes unsuitable insurance products. There are Medicare beneficiaries who have been placed in a MedicareAdvantage policy without their knowledge, or at least their understanding, when they thought they were signing

up for a PDP. There are PDP sponsors selling policies from kiosks near pharmacies in large retail stores. State regulators are very concerned about the aggressive marketing practices of certain PDP sponsors. Consumers are not receiving adequate protection and we urge Congress and the Administration to be more aggressive in their oversight.

We also urge more operational oversight by PDP sponsors of the brokers and agents that sell their products. Recent reports of stolen applications for coverage under Medicare Part D and computer leaks that have exposed thousands of Medicare Part D beneficiaries to the threat of identity fraud are very troubling and raise serious concerns about the carriers' lack of control over their Part D processes and procedures. PDP sponsors must be required to dedicate sufficient resources to ensuring compliance with applicable federal and state law and company rules.

Unfortunately, CMS, the agency responsible for protecting Medicare-eligible Part D consumers, has placed hurdles to state efforts to assist in the protection of these same consumers. State regulators have attempted to clamp down on cross-selling of non-Medicare products, but CMS marketing guidelines explicitly allow such advertising and sales activity. Many state regulators have required agents and brokers to be appointed by an insurance company—thus requiring more oversight and responsibility by the carrier—but CMS has challenged state authority to require agents who sell PDP products to be appointed by the PDP sponsor. This weakens the ability of regulators to hold the PDP sponsor accountable for the actions of its agents and brokers selling their products.

Fundamentally, state regulators have the expertise and experience necessary to protect consumers from aggressive or unethical marketing and sales practices, but state authority has been limited or preempted by the federal government. The states and the federal government need to work together to end these questionable and harmful sales practices, thus securing confidence in a valuable program and providing the proper protections for our Medicare-eligible consumers.

Complaints and Consumer Assistance

One of the most frustrating elements of the Medicare Part D program is the limited ability state regulators have to directly assist consumers. The preemption of state authority over the operations of PDP sponsors—except licensure and solvency—means consumers must go to CMS for assistance. However, state regulators have a closer connection to their citizens, more dedicated resources, and greater expertise in dealing with consumer complaints than CMS. For example, states have received complaints concerning Part D reimbursement to pharmacies, non-payment of claims due to plan confusion, premiums being withdrawn from bank accounts long after requests by beneficiaries for disenrollment, and delays in enrollment. States have received, and continue to receive, questions about drug formularies and cost-sharing provisions of plans. States address these kinds of issues on a daily basis with other types of health insurance and could do the same for Part D beneficiaries if allowed and if provided with adequate resources.

To enhance the ability of the states to assist their citizens, the NAIC is working with CMS to develop a formal process for sharing complaint information regarding the activities of PDP sponsors, agents and brokers. We are hopeful this will improve our ability to protect and assist consumers in our individual markets. We urge Congress and the Administration to work closely with the states to ensure the highest level of protections and consumer assistance for Medicare Part D beneficiaries.

Consumer Choice and Education

There is equal concern among many state regulators about the large number of plans, which have different formularies, cost sharing provisions, and premiums, that are available in the Medicare Part D program. While choice is an important element in the market, too much choice can lead to confusion and possible consumer harm. The value of any health insurance product is maximized when the purchaser understands what the policy covers and does not cover. As the program evolves, we encourage Congress and the Administration to consider opportunities to simplify the process of selecting a plan, while maintaining adequate consumer choice.

To mitigate problems beneficiaries may have in selecting an appropriate Part D plan, the NAIC supports the extension of the initial enrollment period through the end of 2006. This will provide Medicare beneficiaries sufficient time to consider their options and make the right enrollment choice without penalty. This extension would also allow beneficiaries who have mistakenly enrolled in one plan to switch to an appropriate plan without penalty. As the NAIC recently wrote to the Senate, "It is imperative that as many people sign up as possible to spread the risk as broadly as possible and ensure the success of the program." Extending the deadline will

"grant consumers sufficient time to be educated and choose the coverage that is right for them."

Finally, the NAIC also encourages Congress to increase funding for the State Health Insurance Assistance Programs (SHIPs) to $43 million per year. SHIPs provide crucial education, counseling and outreach services to Medicare beneficiaries throughout the country. These services are particularly needed now as the Medicare Part D roll out continues.

Conclusion

In conclusion, I would like to reiterate that the Medicare Part D program has provided much-needed prescription drug coverage to millions of Medicare beneficiaries. However, we must acknowledge, as with any new program of this magnitude, that problems do exist. To address these problems, the NAIC recommends the following:

- Require a PDP sponsor to submit a fully completed application to be filed in a state before a special waiver can be provided;
- Support the state view that the appointment of agents can be required in order to retain a PDP license and to increase oversight of the marketing practices of PDP sponsors;
- Develop specific guidelines limiting the cross-selling of products at the time of a Part D sale to Medicare Supplemental and MedicareAdvantage policies;
- Ensure complaints and questions are answered in a timely manner;
- Consider dialogue on simplification of the Part D program;
- Extend the initial open enrollment period of the program through 2006, and thereby eliminate the penalty; and
- Increase funding for SHIPs.

Thank you for this opportunity to address the Committee. The members of the NAIC look forward to our continued dialogue with Congress and the Administration as the Part D program is implemented.

Mrs. JOHNSON OF CONNECTICUT. A number of you have pointed to the problem of the inability of the program to reach a fair percentage of the very low-income folks. When you compare this program's performance in that arena with Medicaid's long-term performance over many years in that arena, or food stamps, or Quimbies, or any of the other tested programs, you certainly can't fault—at least I don't believe you can fairly fault—the Administration for not having successfully reached good percentages of the very low-income. The fact remains that many who could most benefit and who most need this program are not signed up in Medicaid so they didn't get cross-walked, and they are not signed up in other programs and they are hard to find. They often live in isolated rural areas or in neighborhoods in the city where they never go out and so on and so forth.

Now, all of you have a certain amount of experience with this kind of person. I appreciate your comment that we use targeted lists. The Social Security legislation has already started on that, in that direction. I would like to hear as specific suggestions as you can make as to how we could reach those folks that are not signed up that most need it. The million, you know, a certain number of those aren't going to sign up because they don't want to sign up. That's why it is voluntary. I have had seniors walk up to me and say, "I will never sign up because I can afford not to sign up, and I don't want to sign up," and so on and so forth. That's okay. This group that you are talking about is our joint concern, and any specific recommendations you could make for us to consider I would be interested in hearing. Ms. Ignagni.

Ms. IGNAGNI. Thank you, Madam Chairman. I think there are two issues that I could offer first. The SHIPs are trusted third-

party objective sources. They are terribly underfunded and understaffed. I do believe that the recommendations that have been made by my colleagues should be looked at very, very seriously. As we go around the country and work with the SHIPs, they do need additional resources and they are worth the investment. That's number one. Number two, I think a number of my colleagues have raised the asset test that should be looked at very carefully. One thing that we have heard anecdotally from individuals is the frustration of the requirement that asks you to declare the value of your life insurance policy. We want people to be protected in terms of life insurance. That might be a specific area.

The other area that we have heard anecdotally coming in through customer service is the matter of individuals living with children and how that could potentially create an unintended consequence on the asset test. Those are the two things very specifically we have heard from individuals. I think that to some degree, people are very intimidated about going forward and declaring, and with the concern about how this might impact them.

Mrs. JOHNSON OF CONNECTICUT. Mr. Pollack.

Mr. POLLACK. Madam Chairman, I believe that here is an area where we may have a consensus about some things that can be done. First, let me underscore something that Karen Ignagni just said. The SHIP programs, I think, are the most trusted source of information about Medicare generally and about Part D specifically. To the extent that they have adequate resources, it is important to understand that there are about 12,000 people who work in the SHIP programs. The overwhelming majority of these folks are volunteers. We really do need to provide them with help. We need to get more people in the SHIP offices.

I hope at least one bipartisan thing can be achieved as a result of these hearings today, and that is let us get more money for the SHIP programs. I think that is going to be the most effective way of reaching people. I think there are a couple of other things we can do. Building on what Jim Firman was saying, about the Social Security Administration. The government actually has records about the income that people receive through Social Security. Now, that may not be their entire income, but it is a good presumptive list of which people are the people we should be targeting. We should have the Social Security Administration send out some kind of notice or try to bring in people to check their eligibility for low-income eligibles.

Mrs. JOHNSON OF CONNECTICUT. Mr. Pollack, if I may interrupt. I think that is what they have just done. Didn't they do that once before a few months ago?

Mr. POLLACK. They sent out a notice about a year ago. It is really now time to do this again, given the number of people who haven't signed up. I think we could narrow the list of who to try to go after, and I think that——

Mrs. JOHNSON OF CONNECTICUT. We will check on that, but my understanding is they have sent a letter just in the last week or two to an income category of people. We will check on that because clearly that is——

Mr. POLLACK. To the extent that that is done, that is terrific.

Mrs. JOHNSON OF CONNECTICUT. It will have to be done a second time.

Mr. POLLACK. I just want to add two other things. Karen mentioned earlier about the assets tests. I think there are two facets about the assets test that are really critically important. The assets test does render some people ineligible who I think any of us would agree have very limited means to pay for their prescription drugs. In addition to that, it creates administrative obstacles in terms of getting people signed up because people need the documentation to demonstrate in fact that their assets are X rather than Y. I would suggest that that is something worth doing.

Lastly, Mark McClellan said earlier that there are a number of people who have been signed up, whether they are getting their coverage through the VA or some other method, who are low-income. We should make sure that those people who we think are low-income, who have signed up through some other means, that a notice is sent to them so that they know that they may be eligible for these special subsidies. To be signed up for the program and to have special subsidies are two different things, and we want to make sure that those people have those subsidies.

Mrs. JOHNSON OF CONNECTICUT. Mr. Firman.

Mr. FIRMAN. You asked a question that is dear to my heart. I think the first thing that the Congress should do is not settle. It is very easy to get complacent and say that enrollment rates for other programs have not been very high and therefore it is okay for this program. I think that would be tragic. It is clearly not the intent of the Congress, and it means millions of people will continue to miss out on benefits. I would urge that this Committee and the Congress set the expectation that at least 90 or 95 percent of people are eligible for this benefit should be found and enrolled, and charge CMS and SSA and the private sector with the strategies for coming back to do that.

Specifically, in our testimony, we identify a variety of specific elements that are necessary to do this. First of all, the government cannot do this alone, for a whole variety of reasons. The government is not able to use lists in the same way the private sector is because of the privacy issue. The government is not able to write a letter that is convincing. If you read the letters that the Social Security Administration is sending out, they would not prompt most people to action. They are just limited by law in terms of what they can do. We need to allow others to make approaches, trusted nonprofit intermediaries to make these things happen. Secondly, we need to understand that more support for grassroots organization like SHIPs, area agencies on aging, and other nonprofit groups is needed to improve the way that works. Therefore, there has to be adequate financing.

Our benchmarking studies have shown that it costs somewhere between $50 and $150 to find and enroll a low-income senior in this benefit, and Congress appropriates $10 million to the effort with no reason to think that you are going to get more than $100,000 or $200,000. The level of investment by the country is not commensurate with what is needed and what—all of the benchmark data it takes to enroll these people. Third, we need to recognize that we ought to have specialists who do LIS work. There are

specialists in the SHIPs specialty call centers. This is a very specific job to reach out and assist people with these things. Finally, we need to focus on evidence-based approaches.

I want to agree with my colleague, more funding with the SHIPs makes sense. There are two aspects for the assets test. First, I would like to see it eliminated. The two things that should be done, in our view, are first of all, take away the question about the cash surrender value of your life insurance policy. Nobody knows it. Nobody knows how to figure it out. It is a huge barrier. Secondly, eliminate the counting in-kind support if you are living with another person. Somehow you have to figure out the value of the sewage and the garbage delivery, which are fundamentally impossible. If we eliminate those, we make it much easier for people to fill out the application. Finally, we need to recognize this is a problem for all Federal benefits, and it is in part the problem because of the category I call "nature of each benefit." To say that SSA does SSI outreach, Medicare does Medicaid outreach, food stamps does food stamps outreach, we need a person-centered approach. When you find a person, get them into all of the benefits they are eligible for, not just one. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Do any of you have any information about whether the States that don't have asset tests have a higher percentage of low-income eligible participants signed up as opposed to those who do have asset tests?

Mr. STARKOWSKI. I think in the State of Connecticut we noticed when we tried to impose an asset test on our ConnPACE program, we had it on there for a very short period of time. A number of seniors literally dropped out of our program. Without the asset test, the program was much more attractive. Our ConnPACE enrollment continued to go up. What has happened even now with our ConnPACE recipients who are required to go in to the Medicare RX program if they are eligible—and that's about 96 percent of them—a significant number of them would have been income-eligible for LIS but are not eligible for LIS because of the asset tests. I think it is a real discouragement for people and it does—it actually moves them into the category without having the assistance that they need.

Mrs. JOHNSON OF CONNECTICUT. If any of you can get back to us with that information about the States that don't have an asset test versus those that do, that might be useful.

Mr. GOMEZ. I could proffer one quick thought. I asked a colleague about our senior care program in Wisconsin which does not have an asset test, and it is a competitive, I guess, drug benefit program that has been around for quite some time that we obtain on a waiver, but it's not asset test-based. The co-pays and deductions over the course of time will be different based upon a person's resources, but roughly, I think about, probably, close to 100,000 people are in that program and probably the vast majority of them are folks who would be probably eligible for the subsidy. That is sort of a helpful answer. I am not sure.

Mrs. JOHNSON OF CONNECTICUT. Before I go on to my colleagues who I want to let question here——

Mr. FIRMAN. Nobody—the asset test is inherently discriminatory against renters in this country. If you own your home, you can

have $3- or $400,000 in a home and you can get the benefit. If you are a renter and you have $20,000 in the bank, you don't qualify. To me, it is another reason to eliminate the asset test for consideration.

Mrs. JOHNSON OF CONNECTICUT. Thank you. I do want to urge all of you, because you all have lots of connections, you have got to try to get the States to think through using some of the savings, that they have to develop programs like Connecticut has and Pennsylvania has and Wisconsin has, because 150 percent of poverty income is not enough to be able to pay 3,500. I do not want to be a part of developing a program that doesn't require me to pay $3,500 before the government—that is my children for the most part, because the taxpayers pay the majority of this money, have to pay more taxes to pay my 75 percent subsidy. Right now $1 of every 2 Federal dollars that comes in each year goes to people over 65. Don't guess, don't suppose, don't ever imagine that we will get rid of this gap. What States have the opportunity to do is to adjust that gap. Use some of their savings to adjust that gap to where people can reasonably be expected—because the law allows your family to contribute. It allows the United Ways to contribute some funds to help. The patient assistance programs now are back in here. We need to encourage States to do what some other States have done and take the responsibility to adjust that but—for not every State is 150 percent of poverty income all that low.

In New England where costs are high, it is completely inadequate. Remember the structure of this program makes it not like Medicare, but not like welfare. It is a thoughtful—although it has never been described this way in the press—it is a thoughtful attempt to minimize the impact on future generations of a comprehensive health benefit for our seniors. If this doesn't work, there is no question in my mind but that Medicare will go exactly down the same drain that Medicaid has already gone. There are several things in the Medicare Modernization Act that were set up to flatten that spending while at the same time improving the quality of health for our seniors, and you can't do it without drugs. We did expand it. I want you to remember that and to remember that that 400 million estimate was 2 years of no program, 2 years of program. Every year thereafter, that estimate was going to go up, just like for the estimate for anybody else's plan on the table that year. We can't get involved on those issues. This is costly, but it is a tool. It is a tool to keep people out of hospitals and emergency rooms, and if we don't do that we have no chance of saving Medicare. That is to me the big picture.

I need your help in lobbying States. I would be happy to write them letters myself. It is their public duty to use some of their savings to create a sponge arena in which the Federal program and State need can more appropriately address the needs of our seniors. Thank you. Mr. Stark.

Mr. STARK. Thank you, Madam Chair. We have heard—several of the witnesses have testified, and I suppose others would answer that the donut hole is a problem. It may come as a rude awakening for beneficiaries. Mr. Merritt, there really is, as near as I can determine—and I would ask whether you can fill us in on this—there is no reason that the donut hole must be there. It is not required

by law, as I understand it, and any one of your members could raise the deductible or change the co-pays or charge extra for brand-name product. They can do a lot of things if they were trying to maintain the same loss ratio. Is there anything that is sacrosanct about the donut hole that would prevent a benefit manager from finding another way to save money?

Mr. MERRITT. No. PBMs are basically resource stretchers who try to accommodate these benefit designs. I think, as Dr. McClellan mentioned, everybody has access to a plan that fills a donut hole. PBMs do things that slow the road to the donut hole, offering mail order, pushing generic substitution. Once you are in the donut hole, this is some relief that is offered. Namely, we negotiate discounts on the prices. On 35 percent at retail, 45 percent if you use mail order——

Mr. STARK. You could start at the beginning or the end or be substituted by other savings or reduction in usage plans.

Mr. STARKOWSKI. Donut holes don't result in the commercial balance. Some of our plans do offer generic only, and I am sure more innovations will be to come.

Mr. STARK. I wanted to ask Mr. Gomez, and I hate to ask you to chase back into your records. They have probably been long destroyed. I used to, in my younger foolish days, be licensed by your Department, and I am sure that they have tightened the requirements measurably since then. I am concerned that without your organization, we don't have really any consumer protection. We worked in close concert with the National Association of Insurance Commissioners when we wrote the Medigap rules. It is my understanding you would still enforce those in the 50 States. Now, there may be a move here to do away with insurance commissioners, so we get 49 more Members of Congress to get in here and cause us a lot of problems. Absent that, assuming that we wanted to perpetuate the job that insurance commissioners have done throughout the country, ought we not to allow insurance commissioners in concert, I would submit, with CMS, to regulate sales practices and to license agents and to license companies as they have done so well for the last century or so?

Mr. GOMEZ. Yeah. My answer to that would be yes. It would be helpful to expand our oversight in certain areas. One of the disconcerting aspects of the waiver issue is that we really do function in an environment where we are accustomed to looking at a company managing a book of business in our own States, looking at their solvency, looking at their marketing practices, looking at the risks that that company brings to our markets and to other markets, and we can actually take regulatory enforcement action at the business level to——

Mr. STARK. You can't do that under Part D. You don't have any regulatory enforcement clout.

Mr. GOMEZ. There is very limited things we can do in the Part D world. Certainly with PDP plans. In the environment where they are health insurers, where there are also sponsors for PDPs, there is a better relationship in working out issues based on the insurance relationship. In the stand-alone environment, it is almost impossible. I clearly, on the marketing side of the fence, you know, the preemption questions related to that have been very dis-

concerting because we would not allow some of these marketing practices to exist that have existed in some of the literature——

Mr. STARK. Would your membership be willing to work in concert, as they did in the Medigap many years ago, to have a joint Federal standards and State regulation partnership, if you will?

Mr. GOMEZ. The organizations worked with CMS and actually Congress in the past relative to the Medigap changes. Also with regard to this Part D rollout, we were asked to reshape two of the Medigap plans, extricating the Part D coverage and creating two other plans. That was the model upon which the plans were moving out. We are familiar with that process, and we are capable of doing that.

Mr. STARK. One more quick question if the Chair will indulge me. We may have to vote next week on a bill out of a different Committee. in effect, it would create a universal domicile by letting an insurance company in one State sell in the other 49. I assume that your organization would oppose that.

Mr. GOMEZ. That is H.R. 2355, I believe. That is—there has been ongoing debate. Our organization has opposed in the past. I believe the Commissioner from Washington State has testified against it, and it is another piece of legislation that would probably further erode our small group market and small group protections in all of the—you know, and all of the issues associated with that.

Mr. STARK. Thank you very much. Thank you, Madam Chair.

Mrs. JOHNSON OF CONNECTICUT. Thank you. The gentleman from Arizona.

Mr. HAYWORTH. Thank you and thanks to all of our witnesses who joined us here on the end panel who represent the width and breath of perspectives. Certainly, since it is the goal of this hearing to find improvements, I think we very much welcome your comments and the constructive nature of the same, even though I am sure there is not complete uniformity. Mr. Merritt, your members have the experience of operating prescription drug plans outside of the new Medicare drug benefit, and you deal with new enrollees every year. Approximately how many patients receive their drugs through a PBM-administered benefit in the private market?

Mr. MERRITT. About 200 million. Basically anybody who has insurance coverage, who has a card that goes to the pharmacy, is using a PBM. It may be a stand-alone PBM that subcontracts to an employer union. It may be a health insurer—as Karen well knows—who has a PBM inside. Basically our tools are used by anybody who has drug benefits, aside from Medicaid, in the commercial market.

Mr. HAYWORTH. With your experience and mine, what changes do you see that could be made to Part D to provide for what all hope for, seamless implementation next year?

Mr. MERRITT. That is a tall order because a lot of this is systems issues. In other words, getting Part D up and running involves a lot of system interface. I think that PBMs have the basic tools to get the job done. That is why we are saving 35 to 45 percent already, right out of the gate. I think that, you know, we just need to work closely with the administration, with policymakers, to make sure that our tools are protected. The biggest concerns that we have are downside risks of politics getting in the way of letting

us do our job. One of the things we are concerned about is micromanagement. Like managing prompt pay, for instance; making us pay pharmacists twice as fast as doctors and hospitals are paid in Medicare. That is not helpful and it adds extra costs. Things like that aren't good. We have the basic framework that we need right now. There is always more that we could have. Basically if we could protect to preserve the tools we have, I think we would be in okay shape down the road.

Mr. HAYWORTH. Thank you very much. My thanks to the witnesses. Madam Chair, I yield back the balance of my time.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Mr. Pomeroy.

Mr. POMEROY. Thank you, Madam Chair. I want to begin by saluting several of the panel members and other people in the room as well. It has been my pleasure to work on senior health insurance issues for many, many years with Mr. Firman, Mr. Pollack, Karen Gunthrock of the—formerly of the Wisconsin Insurance Department. These people have really been there over a duration of time, trying to make sure seniors get fair play in the marketplace.

Mr. POMEROY. I commend them for their continued efforts. I guess we need you now more than ever in light of what we have in front of us. Mr. Gomez, Commissioner Gomez, I chaired your Committee back when I was insurance commissioner. We, among other things, developed the standardization formats called for by Congress. We had a superb working relationship with, at that time, HHS and Health Insurance Portability and Accountability Act 1996 (HIPPA), (P.L.104–191), and this is a working group between commissioners and CMS as you deal with this new assignment with overlapping jurisdictions.

Mr. GOMEZ. There was a group that had pretty much formed, late in the fall, anticipating some of these issues and we have had ongoing dialog with a group from CMS, but it hasn't quite solidified into an ongoing working group relationship. We have work in progress with CMS and I am working out, for example, a memorandum of understanding to share information you know, relative to investigations, et cetera. We have discussed, and have tried to work out some the exact issues I just mentioned currently issues that face us.

Mr. POMEROY. Should CMS kind of get a prod from Congress maybe about getting something established or should we even suggest outlines of what might be a joint working group?

Mr. GOMEZ. I think that might be helpful.

Mrs. JOHNSON OF CONNECTICUT. Would the gentleman yield on that?

Mr. POMEROY. Sure, I will yield.

Mrs. JOHNSON OF CONNECTICUT. I am interested in this idea, but you wouldn't want that working group to do what they did to Medigap, because what happened was those standard policies got fixed and the market couldn't adjust, at least I don't think I would, others of you can comment on this later. I think what is really interesting about the Part D programs is the diversity, and if you want gap coverage for just generics, you can get it. If you want gap coverage for generics you can get it. you pay more and it isn't all on the kids. I like the tailoring and the flexibility, and I wouldn't want to lose that.

Mr. GOMEZ. The first steps we are taking on the Part D aspects are really operational in nature trying to work out some of our differences relative to the cross-selling issue for example. That doesn't take a change in law. Dealing with the question of appointment of agents, that is not another legal, that is not a legislative issue, that is not a piece of legislation that this Congress has to think about.

On the waiver question, we are just asking CMS to enforce the law that you actually enacted frankly. we are kind of going through those operational issues. I suspect that, and I got a very clear impression of how busy the staff at CMS have been, and I get that sense when I go to NAIC meetings, the operational issues currently have them completely overwhelmed and we recognize that. We sort of see how that works out in the private sector when companies that find themselves overextended having over-marketed a product without creating operations behind the scenes to manage the new book of business which they have created through with these Part D plans. There is that disconnection, and I think it has taken them some time and it actually is working out. It has been a slow process, not as deliberative as we probably have all wanted to see, but it is working out so we are currently working on that first aspect, Madam Chairman.

Mr. POMEROY. Reclaiming my time, Commissioner, I am running out of time here. I have to put in a plug for the work product on standardization. I actually think, while it did—I suppose you could say, took some, the bewildering choice that preexisted in the marketplace, we had hundreds of different policy forms, it was used to exploit consumer purchasing behavior. We tried to establish as per congressional direction a spread across the spectrum of coverages so people had a choice whether they wanted a Cadillac, bare bones or something in between. I thought that worked pretty well.

The question I want to direct to Mr. Firman is as you talk about simplification, looking forward, as we try to make this thing a little less bewildering, how do you imagine simplification working, and let's use the Medigap model as something, are—not the Medigap model, let's look at lessons learned in regulating Medigap to see whether they are instructive at all relative to what we now have before us in Part D. That would be the last question I would ask, Madam Chairman.

Mr. FIRMAN. The Medicare Modernization Act is based on the premise of informed consumers being able to make the marketplace work. The reason the Medigap standardization occurred in the first place was because people were not able to make choices. Nothing passed the kitchen table test. You couldn't sit down and compare two plans. I may agree with you, Chairwoman, there was too much rigidity and limited innovation, but the basic fact was the consumer knows what a Medigap plan C is and can compare prices and make choices. The current plan market for Medicare Part D does not pass the kitchen table test. Nobody has a computer on a kitchen table, and with so much variation, it is very difficult to make informed choices, and therefore, people are not truly being informed consumers.

The middle ground on this, I believe, is standardization of terms so that language means the same thing and fewer choices, so that

it is possible for a person to make choices without being at a computer. When you are limited to being at a computer as you are right now and the only thing you look at is current dollar savings, even though we are saying it is an insurance product, there is no way to find out what happens if I get assigned another script, you are really not evaluating the insurance value. I think there is a value in taking some of the best parts of the Medigap legislation led by then-Commissioner Pomeroy and applying those lessons to the Medicare Part D market.

Mrs. JOHNSON OF CONNECTICUT. Mrs. Ignagni.

Ms. IGNAGNI. Thank you, Madam Chair. I think there is another middle ground as well, which is in standardization of presentation. We have mounted an effort now, and we are going to be reaching out to consumer groups and provider groups and pharmacy groups who are hearing a lot from beneficiaries to try to talk about creating some standardized categories, for example, plans that are offering premiums that are lower than the anticipated premium, plans that are offering deductibles that are lowering than the legislated deductible, plans that are offering cost sharing benefits that is better than the standardized package. Then finally, plans that are offering coverage in the coverage gap. We are going to be working closely with CMS offering recommendations on how this information and the plans could be organized along those lines to simplify this kitchen table conversation. I think that would go a very long way. The other side of this is that it is very interesting to see what the ships are reporting and what beneficiary groups are reporting as people go through three or four or five basic questions. it is giving us a sense of what might be particularly valuable here.

Mrs. JOHNSON OF CONNECTICUT. Mr. Ryan.

Mr. RYAN. Thank you, Chairwoman. I came in late, I was in another Committee markup, so I didn't get the benefit of hearing all your testimony and earlier questions. I wanted to ask Ms. Ignagni questions about Medicare advantage. Number one, can you give me an update on where Medicare advantage is vis-a-vis Part D? What is the penetration? How many eligible seniors are participating in it? How many market participants are in MA across the country? How many plans are there out there? You have given the nature of them. Are they mostly fee-for-service? Or are they PPOs and the average premium? Then I wanted to ask you your organization's position on the Shadegg bill. I forgot the number but the one you were talking about earlier.

Ms. IGNAGNI. Congressman Ryan, I would like to, if you wouldn't mind, submit some specific information for the record because with 2 briefing books I didn't bring all of the information that I needed to specifically answer your question. A little over 7 million people now in Medicare advantage, it is a mix of products, HMO's, PPOs, private fee-for-service, and it depends on the area. In rural areas, what we find is that you have particularly, hospital systems that have a monopoly position haven't been interested in doing PPOs or HMO's. They are much more interested in doing a private fee-for-service kind of arrangement. That is where you see more of the private fee-for-service.

Mr. RYAN. How many are HMO region metropolitan wide versus region wide?

Ms. IGNAGNI. Well, we don't have any HMO's that are——

Mr. RYAN. Right. All the Medicare advantage, is it more region wide plans, or are you finding more HMO metropolitan wide?

Ms. IGNAGNI. Local. Definitely.

Mr. RYAN. Definitely local?

Ms. IGNAGNI. They can be operated by different organizations that are both locally based national organizations or regional organizations.

Mr. RYAN. The Shadegg bill, I can't recall the number but the bill, I forgot the title of the bill, where you can buy health insurance from other State regulated——

Ms. IGNAGNI. We have had some concerns about the Shadegg bill. In fact, we have done a great deal of work in looking at how this would affect how these systems, how the current systems operate State to State. I would be delighted to share that with you. We understand that there is an interest on the part of individuals in purchasing the most affordable coverage. We understand that in certain States—and we have been very active in certain States in indicating that there are legislative barriers to providing some of the most affordable coverage that we would like to be able to provide to individuals. Mandates tend to be a problem. Indeed in Massachusetts, for example, while the goal is to create a affordable coverage, the requirement of meeting all the mandates means that you then have to move to sometimes higher co-pays, higher deductibles than you would like to do for this particular population. we don't have the flexibility of doing X number of physician visits, X number of hospital stays and preventive care and generic drugs. We would like to be able to have more flexibility to do that.

Mr. RYAN. I will switch subjects again on transparency, I know this isn't PDP related, but it is similar. What is necessary for a plan to—any health insurance company or plan—to get the kind of transparency data they need to give price and quality transparency on services, physician, hospital services, is it a case that if CMS releases 100 percent case file, that that is enough combined with any particular insurance company's data to give an accurate market of a market-by-market, city-by-city transparency, or what is it that is needed?

Ms. IGNAGNI. You really have to look across all payers, and we have actually launched an effort on the ambulatory side with all the provider specialty society and consumer organizations to put together performance measurement for quality. Now we are talking about extending that to talk about aggregating price information. You can get some reference pricing. You have to look at all the different payers there. Combine the data and then get some highs and lows. That is the ultimate utility from a consumer point of view.

Mr. RYAN. 100 percent filing would help quite a bit, I would imagine.

Ms. IGNAGNI. It is not going to do everything that needs to be done. It is just a combination of public and private data that is very important, because that 100 percent takes you only so far, depending upon where you are.

Mrs. JOHNSON OF CONNECTICUT. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair. Ms. Ignagni, you have raised some questions that interest me. I want to ask some questions about the rebates, the doughnut hole. As you know, seniors are expected to pay a premium every month, but when they get to $2,250 in drug spending, they then have to pay 100 percent of their drug cost, because they no longer have any benefits under the plan, until they hit the catastrophic level at some point further. As you know, the pharmaceutical benefit managers make as much of their profit by negotiating large rebates from the drug manufacturers, often based on the volume of the drug prescribed. That is how they make their money. That means the insurance company often gets a big check back at the end of the year. Is that correct? Is that how it works?

Ms. IGNAGNI. Depending upon how the arrangement is struck, it works in different ways. A number of our plans, as you know, have taken the pharmacy business back and they have their own PBMs. A number of our plans contract with——

Mr. MCDERMOTT. Is there anyplace we could get that data to look at it. Is there transparency——

Ms. IGNAGNI. In terms of the discounts and that sort of thing?

Mr. MCDERMOTT. Yes.

Ms. IGNAGNI. I don't know, Mr. McDermott, anywhere where there is a chronicling of the discounts, and that I can tell you why.

Mr. MCDERMOTT. In the expenditure of public money doesn't it seem to you that we ought to have transparency and full access to what those rebates are and how much it is costing and what is being spent, since we are paying the rebates?

Ms. IGNAGNI. I think what from our perspective, the reason that we—our members negotiate and retain pharmacy benefit managers is because they are able to stretch resources, do the negotiations and provide real value within the premium dollar. That is why we do it on the commercial side. That is why we have engaged in these relationships on the Part D side. That is why we continue to do that.

Mr. MCDERMOTT. The basic idea of this plan is to get it out of Medicare so it is not possible for us to know how the public money is actually being spent. We have a senior who has drug benefits and they lose them, they have to go out and buy the drug at full price while they are still paying a premium for a plan that doesn't pay them one dime, and they are paying, let's say, $20 for the pill, and the drug plan is paying 5 cents.

Ms. IGNAGNI. I think one of the most important factors here to keep in mind is that most consumers will not go into the doughnut because of the efforts of our plans and PBMs to stretch their dollars and prevent them from going into the doughnut. That is a very important——

Mr. MCDERMOTT. You are saying you don't have to worry about the doughnut any time from now to the election. Are the seniors going to come to us and a say hey, what is happening to us?

Ms. IGNAGNI. I am saying one thing we are working hard on is through a variety of negotiations, both on the price side and the on the utilization side, to try to make sure that we do whatever possible to make sure that people don't approach that coverage gap.

Both in terms of offering packages as well as delivering a great deal of——

Mr. MCDERMOTT. They can buy something else that covers the donut hole. Is that it?

Ms. IGNAGNI. Right now, every individual has an opportunity to access a plan that covers coverage in the coverage gap in any State——

Mr. MCDERMOTT. In addition to the premium they are paying for Part D?

Ms. IGNAGNI. Yes.

Mr. POLLACK. Under the rules of Part D we do know, of course, the prices that beneficiaries have to pay. We don't know the prices or the rebates that have been received by the PBMs. There is no transparency with respect to that. The only rules are that some portion of the rebate be passed on to beneficiaries.

Mr. MCDERMOTT. How do we know we have actually done that?

Mr. POLLACK. We don't.

Mr. MCDERMOTT. A year from now in here in our Oversight Subcommittee and we try to audit whether they gave anything back to the seniors in lower premium costs, we won't be able to do it, will we?

Mr. POLLACK. I don't think you will be able to do it. I am presuming there is some passing on of savings. That is what the rules are. I am presuming that they comply with the rules.

Mr. MCDERMOTT. 1 percent?

Mr. POLLACK. That is the point. There is absolutely no standard that has been established concerning how much of the savings, or how much of the rebate actually gets passed on to the beneficiary. I think there may be proprietary reasons that PBMs will claim are bases for not making this information public. At a minimum, there should be some oversight process by the Congress concerning what portion of these savings are passed on to beneficiaries. I think this should be transparent, totally transparent. Even if it wasn't fully transparent, at least Congress and the key Committees of jurisdiction should have that information. I don't think there is any way by which you can have that information under the current rules.

Mr. MCDERMOTT. Because it will hide behind the whole question of proprietary information. Is that the veil behind which they hide?

Mr. POLLACK. I will leave that to Mr. Merritt.

Mr. MERRITT. If I may, first of all, there is a lot of transparency in Medicare Modernization Act (MMA) (P.L. 108–173) right now. CMS has access to our rebate information. The vast majority of that rebate information is passed on to CMS and then it is used to drive lower premiums and so forth for consumers.

Mr. MCDERMOTT. Is it available to us?

Mr. MERRITT. It is not available to anybody but the CMS administrator.

Mr. MCDERMOTT. Why is that? We created the CMS.

Mr. MERRITT. It would inhibit our we ability to get better discounts from drug manufacturers. We play drug companies off one another when they make similar drugs. If they know what the

strategies we are working with against their are competitors, it will severely increase the cost of drugs. This was discussed during the MMA debate. Senator Maria Cantwell put forth a provision that would do just this. CBO scored it and said it would cost $40 billion because it would hurt our ability to maintain discounts.

I would like to just counter the notion, there is a lot of transparency. CMS has to approve every plan, every formulary. They see the information they want to get and they have audit rights.

Mr. POLLACK. I want to, if I may, I mentioned without providing numbers because we are going to do this in the next 10 days, about what has happened to prices with respect to Part D plans. What I said was if you look at Part D plans, the prices for the top drugs prescribed for seniors, have gone up in the few months that the program has been operational. We are not going to generalize it. We are going to do it drug by drug for each of the plans.

One of the things that is curious about this is when you take a look at what the price increases are for each of the plans, there is an incredible similarity between the price increases of the Part D plans and increases in AWP. What that says to me——

Mr. MCDERMOTT. AWP means?

Mr. POLLACK. Average wholesale price (AWP). I don't want to get into the merits or demerits of average wholesale price. We know it is a fictitious number. the average wholesale price numbers give you some sense of what the pharmaceutical companies are doing with their prices. If you take a look at drug by drug, by drug, by drug, of the top drugs prescribed for seniors, the increase in the prices of the plans mirror the price increases in AWP. What that says is that for all the fine theory about let the market work and all of the bargaining that is taking place, actually what is taking place is AWP gets increased by the pharmaceutical companies and gets passed right on to the beneficiaries in this program.

Mr. MCDERMOTT. Sort of an automatic escalator. Thank you, Madam Chairman.

Mrs. JOHNSON OF CONNECTICUT. Perhaps you would comment at the same time there are some studies have that have been done that look at the top 30 or 50 most commonly used drugs and show that about half of them are less cost to our seniors during the doughnut hole than they would be on the Canadian market, so this discount is worth quite a lot. So.

Ms. IGNAGNI. The other point to be said to Mr. McDermott's point is, I think, three quick comments: One, the premium is much less than what was projected, so first of all, beneficiaries are saving month to month, as you know, the $24 average versus the 38 projected; second, most people have zero deductible policies so they are not paying that $250. Most—I can give you the statistics—that most plans operate on a co-pay versus a coinsurance basis. The plans are taking the risk and the responsibility for any increases in the pricing of the particular pharmaceutical products. The other point, I note that CMS has done some analysis of the pricing on the Web sites. I know that they look from the end of December to the end of February, and 82 percent of over 9,000 drug prices were reviewed and they hadn't changed. I am very anxious to see Mr.

Pollack's analysis, but that was, the CMS, the latest CMS analysis that I know of.

Mr. POLLACK. May I make one other point. Throughout the course of this hearing, particularly with Administrator McClellan, there was a lot of ballyhooing of this concept that the marketplace is really working, and the top evidence for it is to look at what has happened to the premiums. We expected the premiums to be $37 when in fact, they are about $25 on average. I would suggest that it is a function of a couple of things that have nothing to do with Part D, at least in terms of the bargaining, anticipating prices, they have not risen as was originally anticipated in 2003. Secondly, a lot of people were doing precisely what I did for my mother in law. My mother-in-law is 92 years old and, even though she has advanced Alzheimer's, she doesn't actually take many prescription medicines.

I wanted to make sure she wasn't going to get penalized. I enrolled her in the cheapest plan in terms of premiums and it happened to be a Humana plan. I think there are a lot of people who enrolled in a cheaper plan, just in terms of premiums. That has nothing to do with the prices and how the bargaining has succeeded or failed. Maybe you can say, that this is the benefit of diverse plans. This has nothing to do with bargaining for cheaper prices. Indeed, as I have said, the prices have gone up.

Mrs. JOHNSON OF CONNECTICUT. We do have 2 more people, so we can't allow the discussion to just run. I would have to say I find your statement really incredible that the rise in prices is slower, but Part D had nothing to do with it, when we have just taken the last group of retail buyers and put them into bargaining positions so——

Mr. POLLACK. I was talking about——

Mrs. JOHNSON OF CONNECTICUT. I am sorry. It is a longer discussion. I would love to get into it. I am confining myself because I have no other colleagues here. I am going to go on to Mr. Becerra and I will go on beyond that. I don't think our discussion at this point of the pricing issue has been complete or balanced.

Mr. BECERRA. Madam Chair, thank you very much. I think this is great. I wish Members had this opportunity to have this kind of conversation more often. I want to thank all of you for your testimony because this is what is going to help us iron out the difficulties that we see in the plan right now. I want to stay on this subject because I think this is the crux of it for seniors. I know for most of the folks in my district, and I have a district that is very working class modest income, this is the biggest issue, can I afford to get on to this plan? Do I leave the modest plan I have now for what is being proposed? Will I lose out on getting coverage for the current drugs that I have to have? Will the plan change my formulary later on so that I won't find the drugs I need on that formulary? This is critical.

Mr. Pollack, I don't know how much you can tell us about the survey that you are going to release, but I would love to hear more because I think it is important especially since we have Mr. Merritt and Ms. Ignagni here to try to have that discussion, so this way we can become a little bit more informed on how to proceed, because I hope as the Chairman said earlier, we are going to have

more hearings on this, especially, I hope, after you have issued your survey, the plans and the PBMs have had a chance to talk more about what is going on, maybe then we can get a better sense of what is at work here. If you can, Mr. Pollack, talk a little more about what you have found with regard to the pricing on drugs.

Mr. POLLACK. We will release that report and make it available to everyone on the Committee. There is one thing I do want to emphasize with respect to the data from the report, and that is, the data comes exclusively, and I want to underscore the word exclusively from CMS as reported by the plans. It is available, it is available on the Medicare Web site.

Mr. BECERRA. When you say that prices have increased substantially, what is substantial?

Mr. POLLACK. If I may, I want to reserve that for the release of the report.

Mr. BECERRA. You are going to wait until the report is issued. Let me ask you this now, to the issue of transparency, and this is where I would ask Ms. Ignagni and Mr. Merritt to jump in. I think Mr. McDermott made a good point. This program is being funded in the main by taxpayer dollars. Consumers obviously would like to know what they are getting. In fact, we are going to have legislation coming up pretty soon talking about how we should let consumers be more informed in terms of what they are getting from their hospitals and doctors. Why not for prescription drugs? Why wouldn't we want—and I know the argument is you can negotiate a better price, sounds like you are talking like you are from the Veterans Administration, Mr. Merritt, because that is what the Veterans Administration does, but yet, they do a far better job than it sounds like your membership does in negotiating prices, because in every respect, I have seen, the VA provides the same prescription drugs that are provided through these plans for far less. They do the same type of negotiation.

It seems to me that consumers would want to know, are we getting the best deal, and by the way, when the plans, the pharmaceuticals, excuse me, are passing along a discount for some type of rebate, has that been getting passed on to the beneficiary, the senior who is buying those drugs? So, give us a better sense of why seniors, the taxpayers, should not know what is being paid by whom with taxpayer dollars.

Mr. MERRITT. Well, first of all, let me start, it is a good question and it one worth answering. Let me see if I can do it as clearly as possible here. First of all, PBMs are more transparent, Medicare PDPs are more transparent than anybody else in the health care system. All of our drug prices for all of the different formularies are available on the CMS Web site——

Mr. BECERRA. I understand your drug prices might be available. However, on you what you paid is not available. It is like the car dealer. You buy a used car from some guy, and you sell it, we know what you sold it for. We don't know what you paid. Now it is a private enterprise. This isn't simply a private enterprise. You are using taxpayer dollars to go along the process of offering these prescription drugs. So, the question becomes, we know what you are offering the prescription drug for. We would like to know what you are paying for it.

Mr. MERRITT. I understand. There is a lot of transparency. That transparency is limited to the CMS administrator, whoever it is and whatever administration, because they are the payer. That information needs to stay with the payer because if it becomes public, it gives the drug companies who are negotiating against and playing off against one another valuable negotiating information, which would increase the cost of drugs ultimately, which is why the CBO scored this very provision by Maria Cantwell, Senator Cantwell a few years ago during this debate and said it would cost $40 billion.

Mr. BECERRA. Let me ask Mr. Pollack to respond to that. What is your take on what you heard Mr. Merritt just say?

Mr. POLLACK. I am astounded about the concept of accountability and that nobody really has any sense——

Mrs. JOHNSON OF CONNECTICUT. Mr. Pollack, that isn't the question he asked. You know, we have one more person. The question he asked was much more specific, what do you think about the fact that the government doesn't know what prices were originally paid, the plan is paying.

Mr. POLLACK. That is what I was answering. It seems to me that given that this is taxpayer dollars, I think it makes absolute sense that at least the Committee with jurisdiction over this, if not the American public, should know how our tax dollars are being spent. I think that there should be an accountability about that, not simply to the administrator of CMS, but, at a minimum, to Congress if not to the American public.

Mr. BECERRA. I know Mrs. Ignagni wants to answer as well. I just want to say we are the ones who has to come up the billion of dollars it will take to actually make this program work. I think, Mr. Pollack, you are right. Ms. Ignagni, please.

Ms. IGNAGNI. Thank you, sir, I appreciate the opportunity. First, I think one thing in health care, one thing relates to everything, we have interrelated components. Mrs. Johnson made an observation that is relevant to your question. Three to four years ago, the pharmaceutical trend was over 20 percent. You all remember that. You all remember how difficult it was for employers to maintain pharmaceutical coverage. We stepped in and applied several tools: First, encouraging when physicians thought it was appropriate to move to generics; second, negotiating with pharmaceuticals manufacturers; third, doing step therapy using traditional older drugs before you go to the newer drugs where they were—safety had been assured, and we saw the reason to do this in the Vioxx situation, et cetera; and fourth, disease management. The drug trend came down from over 20 percent, well below 10, so now it is 7 to 8 depending upon the plan. This relates materially to—and the proof is in the pudding—the premiums that are paid by beneficiaries, the lower deductibles that are paid than statutorily, organized, the lower cost sharing and the coverage in the gap. All those tools are being applied.

Now you ask the question why shouldn't we go the next step and have all of these discounts that are being applied for beneficiaries where beneficiaries can see material savings, why don't we have the disclosed. That is your question. If we do that, we are in an administered pricing system. We are no longer in a competitive

economy. We negotiate with physicians. We negotiate with hospitals. We don't disclose all of those rights because it is part of a competitive process. Similarly, in the competitive process that is how you operate.

If you decide to move in that direction, there would be consequences. I think the CBO research that Mr. Merritt has referred to really bears looking at very seriously because essentially what CBO says is the cliff note version is that once you don't have this kind of negotiation, then all the prices go up so what you negotiate becomes the floor and you can negotiate up from that. to the extent beneficiaries are seeing real savings, getting better benefits than what was legislated, which was better than expectations, that is a value for individuals. Then we come to Mr. McDermott's point about the coverage gap and what can we do to make sure, A, people don't get there, and when they do we provide assistance and so we are endeavoring to talk a little bit about that as well.

Mr. BECERRA. The only problem I have with what you said is that even with these discounts that we have seen applied as a result of some of these market principles, my understanding is that you could still go to Costco and find the same drugs if they are available through Costco for about the same price, if not less, you could go to drugstore.com and find them for a little less; and if you were a veteran go to the Veterans Administration and get the same drugs for far, far less. If you go across the border to Canada you would also find them far less.

Even if we are doing great price negotiations, we are still paying a lot more than some basic avenues that are available for people who make the effort to get there. The problem is for 40-some odd million Americans, it is tough to do to go across the border to Canada or to necessarily become a veteran, that is what makes it difficult to understand why the taxpayer through their representatives can't figure out how we are saving money.

Ms. IGNAGNI. Right. You have just put your finger on why people need access to health insurance coverage and why it was so important to do Part D in my view. I have in my purse an inhaler. I pay $2 at CVS for it because it is a generic. I am sure I can go to Costco, probably get it for a dollar maybe just a little less than what I paid to CVS on my plan. If I rack up all of the drugs that I may take or someone with different chronic illnesses may take, that is the utility of being part of a drug plan. We mobilize all these techniques to try to give you as a consumer the best possible deal. It is in our interest to do that because as the government, the government is paying a capitated rate to the plans. We take the risk.

Mr. BECERRA. Again these are taxpayer dollars. We have to make sure we are getting the best bang for the buck and we know where the money is being spent for that accountability. If it were private sector to private sector that is when the government shouldn't be intruding. These are taxpayer dollars and the taxpayer has a right to know how those dollars are being used. I know Mr. Firman——

Mr. FIRMAN. One simple suggestion to this issue of accountability, what amazes me is most people think about what they are paying in the premium. They don't realize that the government

makes a payment of $1,100 a year on their behalf every year. I think a simple way to get at this issue of accountability is just as informed consumers on a monthly basis that in addition to whatever you pay, the government is making a payment of X per month. That is a much simpler way to make everybody aware of accountability without trying to worry about all the details. I am paying $35 a month, the government is paying another $87 a month, and then let the consumers decide whether they are getting enough for their money or not.

Mrs. JOHNSON OF CONNECTICUT. My frustration is that Mr. Pollack did not answer what I thought was the question. I thought the question is what do you make of the $40 billion estimate CBO attached to Maria Cantwell's amendment. I would also say, how do you explain that the drug prices in the Medicare plan are below the old State Medicaid best price levels? I would also ask you, what senior in their right mind would want the VA plan? It is 61 percent generics. It only covers 33 of the top 100 drugs used by seniors. It only delivers drugs to something like 471 points in the United States of America, and Medicare delivers them to 57,000 points. This sort of mindless comparison of the VA plan with the Medicare challenge is something I am tired of hearing about. now I am going to go on and recognize Mr. Doggett. I know—I held my tongue while I listened to all of you——

Mr. DOGGETT. The Chair made a very important point——

Mrs. JOHNSON OF CONNECTICUT. Excuse me. We are going to recognize Mr. Doggett. I know there is more to this discussion and I injected after I listened to all of guys for a long time, and after Mr. Pollack had completely misunderstood me when I said to you, you didn't answer the question. This is the problem with the pricing debate. We talk beyond each other. I am trying to get us to talk to each other. Mr. Doggett.

Mr. DOGGETT. Well, Mr. Pollack, just continuing on this issue, if they are going to hide the cost information even to this Committee, shouldn't we at least be able to find out how much of a discount that a company gets is being passed on to the consumer?

Mr. POLLACK. The answer is yes. By the way, I do want to——

Mr. DOGGETT. Don't take all my time but if you want to respond, I will yield you 30 seconds.

Mrs. JOHNSON OF CONNECTICUT. My patience in letting 5 minutes just drift to 10 minutes when I have been here, I didn't even arrange this hearing, I have been here at this podium a long time. Go ahead, but let's try not to repeat what we have already said, and there may be people on the panel who haven't had a say who would like to add to the issue of price-fixing versus accountability.

Mr. DOGGETT. I know these comments are coming out of my time, but if you can give a short response to that, then I want to move on to some other members of the panel.

Mr. POLLACK. CBO actually estimated that if the Medicare Program bargained for cheaper prices, it would cost the taxpayer money. I understand that that was part of the projected cost. Of course, if you take a look at what the VA charges, it is an enormous difference. I beg to differ, Madam Chairwoman, in terms of access to drugs. If you really examine the VA system, yes, they, of

course, have a formulary as do the Part D plans. Ask veterans who want to get drugs that are off the formulary, and they will say that the VA system is rather flexible in terms of enabling people to actually get the drugs, even if they are not on the formulary.

I am amused about two arguments I hear about who we shouldn't have a VA type system of bargaining. One argument is it is going to cost more money if you have that kind of a system. Then the other argument is, it is going to cause the drug companies so much difficulty in terms of their loss of revenue we are going to see an end to research and development. The two arguments obviously are totally contradictory, and yet those are the explanations I get each time about why we should not have a system like the VA system. It does save an extraordinary amount of money, and not with an inflexible system in terms of access to drugs.

Mr. DOGGETT. While I fully agree with that, I want to refocus your attention on the extra help program for just a moment, because I think it is very troubling when members come here and defend and rationalize and justify and hold to very low expectations a bureaucracy that has been unable to sign up three of four people that are entitled to extra help assistance.

I think, Mr. Firman, putting it in terms of expectations as you did, is exactly where we need to be. We have to set high expectations for the bureaucracy instead of comparing it to what happened in Medicaid. We need to be looking at part B, where, as I believe you were referring, 90 to 95 percent of the people are participating in part B and set high expectations, even if that calls for involving specialized professionals to get the job done. As we look at how we might have additional tools to do better than a 75 percent failure rate, one of the ones I have raised with Dr. McClellan, Mr. Pollack, is the question of whether or not since Social Security already has the Social Security data and the VA data and the retired Federal employees data, wouldn't we benefit for those low-income seniors that are not already in the program, their being able to get access just for those people with privacy safeguards to income tax data, do you think that would be helpful?

Mr. POLLACK. Yes, I do. Of course, the issue you raised with Mr. McClellan would also make it simpler because, right now, we don't have good information from the Internal Revenue Service (IRS) or the Social Security Administration in terms of assets. If we eliminated the assets test, we would have a somewhat easier time in terms of identifying the target population that we want to reach out to.

Mr. DOGGETT. As Mr. Firman also pointed out, and I think it is a basic family value issue, there is discrimination under the asset test for—you referred to it as a renter, but in the case of many of the people I represent down in the River Ann Valley, it is someone who perhaps is physically or mentally incapacitated and then live with their children and they no longer have their original home, under the asset test as it is now, they are at a considerable disadvantage, aren't they?

Mr. FIRMAN. Yes. That is absolutely right. You know, we have all these rules about counting assets where, like the life insurance policy and the inkind support, there is no reason to have it. It is

just a barrier. I think we should eliminate the asset test. If the intent of Congress is to have people have the benefit, they should do that. One point on your first point, sir, is that one way to approach it is to try to change the Social Security law or the IRS law to allow these things to happen. It may not be necessary to do that, if there is more cooperation among States and that is exactly the reason we set up a new nonprofit cooperation called the Benefits Data Trust to be able to accept data from States, from CMS, and from private sources to accomplish some of those goals.

We would certainly support the legislative fix. It may be possible that a public private partnership can do some of this right now what would be helpful would be, as you said, sir, to keep the heat on, create the expectation, ask SSA and CMS to come back with a plan about how they are going to achieve 95 percent takeup rates and not accepting the much lower results we have right now.

Mr. DOGGETT. Thank you.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much for your testimony, despite the chasm of difference of opinions amongst members and amongst panelists as to whether competition lowers prices or whether it doesn't, the kinds of ideas that you put forward as to how we could improve this program in the next round have been very useful. I appreciable your time. I am sorry to have taken your whole day, but we do appreciate your being here and also this discussion. Thank you. The hearing is adjourned.

[Whereupon, at 4:10 p.m., the hearing was adjourned.]

[Questions submitted by the Members to the Witnesses, and their responses follow:]

Question from Chairman Bill Thomas to Dr. McClellan

Question: Dr. McClellan, PAPs serve an important role by ensuring that low-income individuals have access to affordable, and sometimes free, prescription drugs. Many pharmaceutical companies have indicated they're working with the Office of Inspector General (OIG) to create new patient assistance programs (PAPs) or modify existing PAPs for low-income Medicare beneficiaries who are unable to meet their Part D copayment requirements. As you know, the OIG advisory opinion requires that PAPs provide assistance "outside" of Part D.

While I'm encouraged by the news that pharmaceutical companies plan to continue their PAPs, I'm also concerned about the potential financial windfall this creates for Medicare drug plans at the expense of the taxpayers and seniors enrolled in Part D who's income precludes them from PAP eligibility. Plans will have an incentive to steer all eligible beneficiaries into these PAPs, likely benefiting the beneficiaries but also reducing the plan's exposure to financial risk. Plan bids, premium subsidies, and beneficiary premiums were based on the assumption that plans would assume the financial risk for drugs on their formulary. However, PAPs remove a degree of risk from the plans, yet the plans continue receive the full Federal subsidy on an artificially inflated amount.

Dr. McClellan, has CMS considered revising plan's subsidies to reflect the fact that many beneficiaries will be receiving some of their drugs from PAPs rather than from their Part D plan?

Answer: Part D sponsors are required to develop their plan bids based on their expected costs for providing defined standard prescription drug coverage. As such, Part D sponsors must reflect in their bids any expected change in costs and utilization due to the presence of third-party payers and financial assistance programs such as Pharmaceutical Assistance Programs (PAPs). To compete for Part D beneficiaries, Part D sponsors have an incentive to keep their costs and plan bids low and, therefore, account in their bids for any reduced costs due to the involvement of third-party payers or other sources of financial assistance. These lower plan bids

result in lower premiums for beneficiaries and lower costs for the federal government.

The federal government provides risk sharing payments to Part D plans to limit their exposure to unexpected expenses. To the extent that a Part D sponsor has drug costs that are significantly lower than expected or significantly greater profit due to a beneficiary's use of a PAP, this profit will be shared by both the federal government and the plan through risk sharing.

CMS believes the involvement of PAPs benefits beneficiaries, Part D plans, and the Medicare Program. Therefore, CMS does not intend to revise Part D plan subsidies at this time to reflect beneficiary use of PAPs.

Questions from Mr. Rangel, et al. to Dr. McClellan

[Questions follow:]

BILL THOMAS, CALIFORNIA,
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U.S. House of Representatives

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RAHM EMANUEL, ILLINOIS

JANICE MAYS
MINORITY CHIEF COUNSEL

June 21, 2006

The Honorable Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20500

Dear Administrator McClellan:

Thank you for appearing before the Committee last week to discuss implementation of the Medicare Part D, and for staying through an entire round of questioning.

A number of us asked for specific data at the hearing or have written letters requesting such information. As we discussed, we are putting these requests in writing in hopes of both clarifying the exact nature of the requested data and expediting the answers.

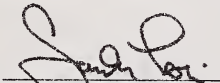
We request you respond to the attached questions by June 30, 2006. Please answer each question by referring to the corresponding number and letter. Questions requiring answers about the number and type of beneficiaries enrolled or not enrolled should be answered with both national aggregate numbers and by state, with the greatest degree of accuracy possible. If you are unable to provide a complete answer to one or more questions by June 30, please provide the answer or data to the best of your ability, explain why it cannot be answered at this time and provide a timeframe for the provision of the final, complete answer.

If you have any questions or need additional information, please contact Cybele Bjorklund on the Democratic staff of the Committee on Ways and Means at 202-225-4021.

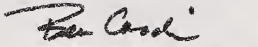
Sincerely,

The Honorable Pete Stark
Ranking Democrat
Subcommittee on Health

The Honorable Charles B. Rangel
Ranking Democrat



The Honorable Sander M. Levin
Ranking Democrat
Subcommittee on Social Security



The Honorable Benjamin L. Cardin
Ranking Democrat
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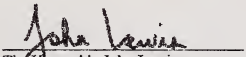
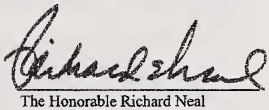
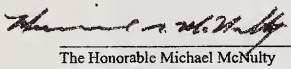


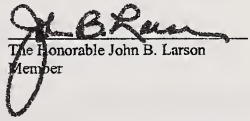
The Honorable John Lewis
Ranking Democrat
Subcommittee on Oversight



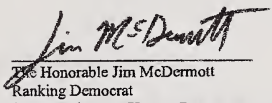
The Honorable Richard Neal
Member



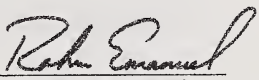
The Honorable Michael McNulty
Ranking Democrat
Subcommittee on Select Revenue Measures



The Honorable John B. Larson
Member



The Honorable Jim McDermott
Ranking Democrat
Subcommittee on Human Resources



The Honorable Rahm Emanuel
Member

The Honorable Xavier Becerra
Member

The Honorable Lloyd Doggett
Member

Questions for Record on June 14 Part D Hearing
Submitted to CMS Administrator Mark McClellan by Democratic Members
Committee on Ways and Means
June 20, 2006

ENROLLMENT AND OTHER DATA

1. **New coverage.** In Q&A, you acknowledged that a large majority of beneficiaries with drug coverage had coverage prior to the start of Part D. You asserted that just 11.6 million beneficiaries – approximately 30 percent of the 38.2 million cited by the Administration as having coverage –have new drug coverage this year.
    a. Please provide an updated version of the first table ("Total Medicare Beneficiaries with Drug Coverage, as of 6-11-06") in your testimony with a new column on the far right showing how many beneficiaries are presumed to be newly covered in each category. Please indicate with an * which categories are funded by Part D (e.g., PDP, MA-PD, Medicare-Medicaid and retiree drug subsidy).
    b. How many PDP enrollees previously had drug coverage through a Medigap plan? How many of those transferred into a PDP offered by their Medigap insurer?

2. **Plan-specific enrollment data.** CMS has refused to release plan-level enrollment data, despite numerous requests from Members of Congress, press, researchers and others. At the hearing, you cited privacy concerns, given apparently low enrollment in some plans. However, this is not an issue since we are not asking for beneficiary or even de-identified demographic information. CMS has the data, or you couldn't be paying the plans or making announcements about the average premiums of enrollees. Thus, please provide plan-specific enrollment data by region and, for the national plans, nationally.

3. **Data on doughnut or coverage gap.**
    a. How many beneficiaries are enrolled in plans with a doughnut hole?
    b. How many beneficiaries are currently in the doughnut hole?
    c. How many do you project will fall into the doughnut hole some time during the 2006 plan year?
    d. How many people do you project will exit the doughnut hole and receive catastrophic coverage? Please provide these answers for both PDP and MA-PD enrollees.

4. **New enrollees.** Even with the closure of the initial enrollment period, there will be on-going outreach, education and enrollment issues for new beneficiaries.
    a. How many beneficiaries are newly eligible each month?
    b. How many are duals?
    c. How many are thought to be eligible for the limited-income subsidy (LIS) or "Extra Help"? Please provide national and, if possible, state-level data.

LIMITED-INCOME SUBSIDY (LIS)

5. **Facilitated enrollment for LIS and Katrina late enrollees.** Regarding the CMS demonstration project that will allow seniors and people with a disability who qualify for the Extra Help or who live in an area affected by Hurricane Katrina to enroll in Part D without penalty through December 31, 2006:

a. Will CMS facilitate enrollment for newly approved LIS beneficiaries or those who live in an area affected by Hurricane Katrina during this demonstration project?
b. If so, how?

6. **Clarification of penalty status for LIS.** You testified that beneficiaries eligible for the low-income subsidy who enroll during the 2006, "will not face a premium penalty for late enrollment," but also that CMS lacks the administrative authority to waive the late enrollment penalty without further Congressional action.

   a. Is CMS "waiving" the penalty for those who sign up for Extra Help during 2006 or is there some other mechanism by which beneficiaries will avoid paying the penalty?
   b. What will CMS policy be on late enrollment penalties for LIS beneficiaries who enroll during 2007?

7. **People denied LIS after May 15.** Regarding beneficiaries who applied for Extra Help before May 15 but were denied LIS status after that deadline:

   a. Since they were awaiting determination of their LIS eligibility on May 15, have you developed a procedure in place to allow these beneficiaries to enroll in a plan before the November open enrollment period?
   b. Will you waive the late enrollment penalty for them if they enroll during the next enrollment period?

8. **Part D enrollees eligible for, but not receiving, Extra Help.** Regarding beneficiaries who enrolled in Part D plans before May 15, unaware of their eligibility for Extra Help, you clarified that they can still apply for the LIS during the demonstration project and receive Extra Help:

   a. Will they be allowed to switch plans after becoming eligible for Extra Help?
   b. Is there a process in place to refund premiums and co-payments to beneficiaries who were always LIS-eligible, but had not previously applied for the subsidy?

9. **Churning among duals.** Every month, tens of thousands of beneficiaries fall in the gap between Medicaid and Medicare drug coverage. These dual-eligibles may go up to eight weeks without prescription drug coverage, and pay hundreds of dollars out of pocket, or worse, go without prescriptions that should be covered by Part D. Regarding low-income Medicare beneficiaries who cycle in and out of the Medicaid program as their expenses reach certain threshold amounts:

   a. What actions is CMS taking to automatically enroll these beneficiaries so that they have Part D (and Extra Help, when applicable) coverage the day their Medicaid coverage ends?
   b. How will CMS treat those who experience periods without creditable coverage because of their inability to pay premiums when their dual-eligible status ends?
   c. How quickly are plans required to reimburse dual-eligibles who have made out of pocket expenditures while in the gap between Medicaid and Part D coverage, and how do beneficiaries pursue such reimbursement?

10. **Treatment of transitional assistance beneficiaries.** Regarding Medicare beneficiaries who received transitional assistance in the Medicare drug discount card program:

    a. How many are still enrolled in Medicare?
        i. Of the answer to 10(a), how many are now enrolled in Part D?
        ii. Of the answer to 10(a), how many are now enrolled in Extra Help?
    b. Please describe CMS' additional outreach efforts, if any, directed specifically to those identified in 10 (a) who are either not signed up for Part D, or are signed up but not receiving Extra Help?

11. **Possible opt-in for LIS screening.**
    a. In order to increase enrollment in Extra Help, will CMS include an "opt-in form" or "check box" in the enrollment materials for new Medicare beneficiaries, which would authorize CMS to screen them for LIS eligibility?
    b. If not, why?
    c. Will CMS require plans to do this for their enrollment and application materials and processes?

12. **Effect of Income and Asset Restrictions.** We are concerned that the current eligibility standards may preclude many truly needy beneficiaries from receiving Extra Help. To help quantify this problem, we request:

    a. Number of people who have applied for the LIS.
    b. Number of people rejected for Extra Help because their assets exceed the applicable limits required by the asset test, the average amount of assets over that limit for those rejected, and the asset or resource category(ies) that caused the disqualification.
    c. Number of people rejected for Extra Help because their income exceeded 150% of the federal poverty limit, and the average amount over that limit for those rejected.

13. **LIS participation among Medicare Savings Plan enrollees.** How many people participating in the Medicare Savings Plans are not enrolled in Extra Help?
    a. Please describe what is being done to reach these beneficiaries.
    b. Please provide copies of any applicable outreach materials.

14. **NCOA materials.** Please provide copies of the grant application, scope of work documents, and all written or electronic communications to and from the National Council on Aging with regard to its "CMS-funded grant to reach and qualify beneficiaries for LIS."

15. **Extra Help communications.** Please provide copies of all communications regarding Extra Help sent to beneficiaries by CMS, the Social Security Administration, and your grantees and subcontractors. For each different communication, please include:
    a. the date(s) sent; and
    b. the number of households to which it was sent.

16. **Future LIS outreach efforts.** On page 13 of your recent written testimony to the Committee, you refer to a new CMS endeavor to "focus future grassroots efforts" in "counties with large numbers of potential LIS-eligibles." Please provide a listing of all

counties (and Metropolitan Statistical Areas and census tracts, if applicable) in which these efforts will occur. For each county or area so identified, please provide:

a. the average per capita income
b. the number of seniors with incomes at or below 150% of the federal poverty limit
c. the number of Medicare beneficiaries
d. the number of Part D enrollees
e. the number of Extra Help enrollees

17. **Outreach to minority beneficiaries and those living in rural areas.** On page 14 of your testimony, you refer to "special initiatives for both minority beneficiaries who live in urban areas and beneficiaries who live in rural areas who may be isolated from community outreach efforts." Please provide a complete description of these "special initiatives" and copies of any printed materials to be used.

MISCELLANEOUS

18. **Customer service data.** Members of this Committee have asked CMS numerous times, including via a letter on April 25, to release data on the customer service provided by Part D plan sponsors, specifically the data collected over the last number of months on plan call centers and other customer service measures. We understand CMS has given this information to the plans on a regular basis. During the Subcommittee hearing on May 3, Dr. McClellan promised to provide the data, yet they still have not been released as of today.
    a. Please provide, by plan sponsor, all of the data that have been collected and any corresponding analyses.
    b. Please explain what specific data will be released to better enable beneficiaries to compare plans based on customer service for the 2007 enrollment period.

19. **Plan quality information.** CMS has been collecting data from the plans on a number of quality measures, including (1) the number of grievances, exceptions and appeals filed per 1,000 enrollees, (2) the resolution of appeals and exceptions, and (3) the number of requests per 1,000 enrollees for prior authorization, step therapy, tier and non-formulary exceptions. We understand that the first quarter information was due to CMS on May 31. Please provide all of the collected information by plan sponsor, and provide the timeline for the public release of data that would allow beneficiaries to compare plans based on these and other non-price (e.g., call center performance) measures.

20. **Rebate information/negotiated prices.** PBMs and insurers make much of their profit by negotiating large rebates with drug manufacturers, often based on the volume of a drug prescribed.

    a. On average, how much of the rebate gets passed onto Medicare Part D beneficiaries in the negotiated price they see at the pharmacy counter?
    b. Given that the law does not require that all of the rebates and discounts be passed on, doesn't this mean that beneficiaries in the coverage gap or donut hole pay more than the lowest negotiated price, while the plan gets a kickback (in the form of the rebate) for their purchases?

c. The law requires that CMS payments be NET of rebates and other negotiations. Is CMS getting the needed information and are you certain that your payments reflect rebates and all other negotiations?

21. **Effects of risk corridor payments.** Please provide both in aggregate terms and specific to plan sponsor or organization whether and how much taxpayers are losing or saving during 2006 through the risk corridor arrangement.
    a. If CMS cannot provide this data by the deadline, when can we get that information?
    b. Do you expect substantial changes for 2007?
    c. If so, why?

22. **Prior authorization problems.** Regarding the numerous stories about beneficiaries being unable to obtain prior authorization for needed drugs that are listed on their plan formularies and doctors being put on hold for hours while attempting to get prior authorization for a particular prescription from plans, what is CMS doing to ensure that plan sponsors meet their obligations to beneficiaries to provide prompt and accurate prior authorization determinations to avoid both health crises and wasted physician and pharmacist time and resources?

23. **MEDICs/fraud and abuse.** In October of 2005 CMS announced a comprehensive project to monitor fraud, waste, and abuse in the Part D program. To date, CMS has contracted with only one Medicare Drug Integrity Contractor (MEDIC) to carry out this work, despite that the Deficit Reduction Act (DRA) provided $100 million specifically for program integrity.
    a. When will the remainder of the MEDICs be in place to monitor fraud, waste and abuse in Part D?
    b. What resources are current being spent on oversight that should be done by the MEDICs?
    c. What specifically is being done with the $100 million from the DRA?

24. **Humana's privacy breaches.** In recent weeks there have reports of two beneficiary data privacy breaches by Humana. In one instance, a widely accessible hotel business center computer was found to contain identifiable data on 17,000 Part D enrollees. In response, you stated, "It is unacceptable when personal information on any beneficiary is put at risk." However, your corrective actions for Humana fail to include any fines for this grave violation.
    a. Why did CMS fail to impose the $10,000 to $100,000 civil monetary penalties available under 42 CFR 423.750(a)(1), if this is so "unacceptable?"
    b. What specific actions have you taken? Why haven't you taken this opportunity to make an example out of a plan that appears to be so careless with these data?

25. **Licensure waivers.** The National Association of Insurance Commissioners has grave concerns about the broad licensure waivers granted by CMS. It appears that in some instances CMS is not even requiring the plans to meet the requirements in the regulations. Please explain.

26. **Price transparency.** The Administration has been advocating for price transparency for certain healthcare providers.
    a. Do you support price transparency and public disclosure of the actual negotiated prices for drugs and the extent to which discounts are passed on?

b. If not, why should this be hidden from the public, especially in light of the public financing?
c. To the extent you are concerned it would undermine the negotiating authority of the plans, why don't you worry that the same holds true for price transparency for physicians and hospitals?
d. Given that a feature of competitive markets is consumer access to information, how will Part D provide the ultimate experiment of the "consumer choice" model if consumers lack significant information?

Question from Mr. Paul Ryan to Karen Ignagni

Question: I wanted to ask Ms. Ignagni questions about Medicare advantage. Number one, can you give me an update on where Medicare advantage is vis-a-vis Part D? What is the penetration? How many eligible seniors are participating in it? How many market participants are in MA across the country? How many plans are there out there? You have given the nature of them. Are they mostly fee-for-service? Or are they PPOs and the average premium?

[The response from Ms. Ignagni was not received at time of printing.]

[Submissions for the record follow.]

Statement of Linda Fullerton, Social Security Disability Coalition, Rochester, New York

Members of the Committee:

My name is Linda Fullerton and I am a disabled American on Medicare Part D myself, and President/Co-Founder of the Social Security Disability Coalition, which is made up of thousands of Social Security Disability claimants and recipients from all over the nation.

I find it disturbing that at this latest hearing on the "Implementation of the Medicare Drug Benefit," that glaringly absent from your panel was representation from organizations such as AFGE/National Council of SSA Field Operations Locals, who to date have helped process nearly 4 million subsidy applications for Medicare Part D, the Medicare Rights Center, AARP and disability organizations such as mine. We are all heavily involved with the implementation of the new Part D program, and continually hear the horror stories of what needs to be done to improve it. A majority of our members are actually enrolled in the program ourselves. Who better to give feedback at these hearings than those who are directly affected by its flaws! I ask that in future hearings more concerted effort be utilized to include a better represented cross section of the American population. It seems to me that if this is not done, that you are not getting a total reflection of the population affected, and are making decisions on inaccurate information which can be very detrimental to those whom you have been elected to serve.

I am also disturbed by the fact that the majority of the time that the Medicare Part D program is mentioned, that the disability population which also relies heavily on this program, is rarely referred to. It is mostly promoted as a "retirement" benefit. Currently disabled Americans are forced to wait 2 years to be covered under Medicare A, B, or D. That needs to change. My organization agrees totally with the Medicare Rights Center, that coverage under all parts of Medicare must start immediately for them, upon disability date of eligibility. I personally endured financial devastation during that waiting period, that along with my enormous wait/struggle to get SSD benefits, I will never been able to recover from, since I am permanently disabled and can no longer work.

HMO's are forcing their subscribers to use their Part D plans or lose Medicare health insurance coverage in their HMO plan. Since I am enrolled in a Medicare health insurance plan with an HMO, I was not allowed to "shop" for the best Medicare Part D plan to suit my needs, which was promoted as a sign up "incentive", or I would have lost my health insurance with that plan. This practice should be made illegal as it restricts a patient's ability to shop for the best Medicare Part D for their personal pharmaceutical needs. While this may have made enrollment in Medicare Part D an easy process, this was an obvious "sell out" to the HMO's. Many are even paying more for their drugs than they were before Part D took effect when co-pays and premiums are factored in. Under my HMO Part D plan, I pay more now for each drug I need, than on my previous HMO provided drug plan before Part D took effect. My monthly HMO premium doubled, and I still have additional co-pays for each drug, with less choices. I recently got major sticker shock when I went to my pharmacy. I was told that one drug I was just prescribed would cost me over $100 since it was not on my drug plan's formulary. I was instantly forced to make a decision that I never had to before. Do I not eat for 2 weeks, go without health insurance for two months, or do without two other medications I need for a year? Since I am on Social Security Disability, my only choice was to do without the $100 medicine and walk out. HMO's are getting huge drug contracts under the current plan but not passing on the savings to consumers. My additional Part D cost is not even in line with the average $25 per month premium, that was suggested by the President when he visited my area this Spring to promote sign up for the new Part D plan.

The Part D plan should be revised to allow Medicare beneficiaries to enroll in a SINGLE drug plan provided directly by Medicare so that premiums, deductibles, and co-payments, would be the same for everyone. This drug plan would be the same as the one currently in place for all other Medicare benefits. Those who want to enroll in a private plan for drug coverage could still do so, just as is allowed for other Medicare benefits. Under this proposed plan Medicare could only remove drugs after one year and must set up simplified appeals procedures so doctors/patients would always be guaranteed access to ALL medicines required to insure proper healthcare for patients.

Americans must have continuous TOTAL drug coverage by removing deductibles and gaps in coverage especially the "donut hole." Very often people who need expensive life saving drugs such as Cancer or Aids treatment medicines reach that gap in coverage after 1–2 months, and are then without any coverage, having to spend

thousands of dollars, and forcing them into poverty in addition to their health problems. These sorts of stipulations are also very confusing and obviously harmful to those who desperately need life saving prescription medicines, especially those with terminal or chronic illnesses that can least afford it.

The current Medicare Part D plan is structured to be an outrageous sell out (pharmaceutical payola) to the drug companies since there is no provision for Medicare to shop for the best drug prices. That needs to be changed to allow Medicare to freely shop for the most cost efficient medicines and increase the types of medicines available on the Part D formulary. Medicare must also work with the FDA to lower the amount of time that drug companies can hold patents so that more generic drugs are available in the marketplace which would lower drug prices across the board. Congress should also pass Federal regulations (similar to those governing the tobacco industry) that prohibit the pharmaceutical companies from advertising their "prescription only" products to the general public, as this has greatly driven up the price of medicines in order to pay for these types of "commercials."

In fiscal year 2006 alone as determined by the SSA, their employees will process approximately 528,000 Medicare Part D low income subsidy applications. SSA has already experienced staffing cuts in 2006, and based on the President's proposed budget, is expected to experience even more staffing cuts in 2007. As a result of poorly trained and overworked SSA staff during the Medicare Part D sign up campaign, there has not been enough properly trained SSA employees to answer questions accurately or in a timely manner. In addition, starting in January of 2007 the Medicare Part B tax will be increased, creating another flood of calls to the already overburdened SSA 800 number and visits to understaffed SSA field offices. To date Congress has not provided any additional funding for staff to handle the expected work load increase for the Part B change. With this additional change to another part of the Medicare program, it is sure to have a negative effect on the quality of service on both the Part D and Social Security programs as well, since staff will have to be drained from these other programs to handle the new Part B change. All indications lead me to believe that it is only going to get worse, instead of better in the years to come and this is totally unacceptable. Congress needs to properly fund these programs immediately so more well trained staff are put in place to handle the increased work load that the changes to the Medicare program are imposing on both the Medicare and Social Security programs. Increased staff levels must be maintained even now that the initial Medicare Part D signup deadline has passed, since the number of people eligible for these benefits is only going to increase over time as the American population ages at a faster pace compared to decades of the past.

There should never be penalties for those who do not enroll in Medicare Part D or any other portion of the Medicare program. Medicare is supposed to be there to keep people healthy, not force them into having coverage, and penalize them into poverty for the rest of their lives, if they miss a sign up deadline. Medicare should be a healthcare program that rivals any private insurance coverage offered, and one that people would rush to sign up for on their own without the fear of penalties. In spite of your "positive" Medicare Part D enrollment numbers, and the way that the current Medicare Part D plan is structured, many disabled and elderly citizens, including myself, are still having to decide whether or not to eat, pay heat/utility bills, give up other necessities in life, or go without their medicines instead. No American citizen should ever be forced into making those sorts of agonizing choices. I ask that you do right by the American people and reform this vital healthcare program in an expedient manner. We may be disabled but we vote! Thank you for your time.

Sign the Social Security Disability Reform Petition—read the horror stories from all over the nation:

http://www.petitiononline.com/SSDC/petition.html

Social Security Disability Coalition—offering FREE knowledge and support with a focus on SSD reform:

http://groups.msn.com/SocialSecurityDisabilityCoalition

Please check out my website at:
http://www.frontiernet.net/~lindaf1/bump.html

Statement of Robert M. Hayes, President, Medicare Rights Center

The Medicare Rights Center appreciates the opportunity to submit testimony to the first oversight hearing on the Medicare Part D prescription drug benefit held by the full Committee on Ways and Means. This hearing is long overdue.

Staff and volunteers at the Medicare Rights Center have spent the last six months fighting to get people the medicines they need under the Part D benefit. If you look at the roll out of Part D without a political or ideological agenda, you will see that many people have been hurt by the structure of this benefit and by the implementation of the benefit by the Administration and its insurance company collaborators. You will also see that countless people are paying lower costs for medicines that they need. We, and many others around the country, have worked and continue to work to ensure that the poorest Americans receive the financial help that is their right under Part D. Sometimes we were able to help; too often we were not. We work in the trenches day in and day out helping people with Medicare who face problems with the system. There have been too many problems with the Part D program to list, but we have learned valuable lessons during these first months of the Part D benefit and it is those lessons that we will share with the Committee.

The Medicare Rights Center is a not-for-profit consumer service organization, with offices in New York, Washington and Baltimore. It is supported by foundation grants, individual donations and contracts with both the public and private sectors. We are consumer driven and independent, relying on a small staff and hundreds of deeply committed volunteers to carry out our mission. We are not supported by the pharmaceutical industry, insurance companies or any other special interest group. Our non-partisan mission is to serve the 43 million men and women with Medicare.

Through national and state telephone hotlines, casework and professional and public education programs, MRC provides direct assistance to people with Medicare from coast to coast. Each year, the Medicare Rights Center receives over 80,000 calls for assistance from people with Medicare. Our counselors are trained to assist consumers with complex problems and we complement the basic services offered by the 1–800–MEDICARE hotline operated by the Centers for Medicare and Medicaid Services (CMS). Indeed, for a number of years 1–800–MEDICARE has been the largest source of referrals to our hotline; MRC receives no CMS support for its consumer hotline.

MRC also brings to professional counselors, care givers and consumers across the country *Medicare Interactive,* a web-based counseling tool—developed with major foundation support and with a seed technology grant from the United States Department of Commerce. *Medicare Interactive* assists people with Medicare access benefits, including Part D.

We reach out into low income, minority communities and, in recent months, have concentrated our services on enrolling people with Medicare in low income programs—the Part D Extra Help Program and Medicare Savings Programs, especially QI–1.

We have launched a Part D appeals program, recruiting a battery of volunteer lawyers and physicians to assist people with Medicare to obtain medications denied by their Part D plans. Drug plans place the Medicare Rights Center's toll free phone number on notices informing their enrollees that the Part D plan is denying coverage of a prescribed medication. Since we receive no federal or state financial support to assist people with these Part D appeals, we can only make a dent in the great need for this assistance. The Committee should know that without competent, independent representation, the Part D appeals and exceptions process is, for most people with Medicare, a sham.

The eight policy recommendations we make are the fruit of lessons learned helping people with Medicare navigate this new drug benefit. We have no political or commercial interest that interferes with our intent to propose sensible, non-ideological public policies that serve the interest of people with Medicare.

I have been using Aciphex since 2000 for acid reflux. It worked fine but was not on the Medco formulary. I filed an exception, with a statement from my doctor that I had tried all medicines on the formulary and none had helped me as much as Aciphex. Medco made it a Tier 3, non-preferred drug. I still have to pay 75 percent of the cost, $284.50 for a three-month supply.

Under my former plan with the State of Virginia, I only paid $32 for a three-month supply. That plan stopped covering drugs once Part D started. I appealed to have it made a preferred drug but it was denied, so I have to pay $1,138 for the medicine I was paying $128 for last year. My breast cancer has since returned in

my lungs and I have to take chemo, which is hard on my digestive system. I am going to try to appeal again.

Alice
Mechanicsville, Virginia
Story submitted to Part D Monitoring Project

Evaluating Part D

Some members of this Committee and spokesmen for the Administration claim that the figures released last week—over 38 million people with Medicare now have drug coverage, the administration says—are proof that the Part D program is a success. Enrollment figures, especially enrollment figures designed to inflate the impact of Part D, do not tell the story about this new program.

First, a breakdown of the numbers:

According to the Administration, 9.3 million men and women have drug coverage because they are retired federal employees or military veterans or they get coverage from a current or former employer with no Medicare subsidy. Their drug coverage has nothing to do with the Part D benefit.

Another 6.8 million people have coverage through a former employer that is now subsidized by Medicare, not through a Part D plan.

Roughly 6.3 million people lost Medicaid coverage on December 31 and were automatically enrolled into a Part D plan. Overwhelmingly, the coverage they receive under Part D is worse than they had under Medicaid. There are more restrictions and higher out-of-pocket costs. The fact that New York and California, both states with Republican governors, have maintained Medicaid drug coverage as a safety net for these dual eligibles—people with Medicare and Medicaid—into June speaks volumes about the deficiencies of Part D.

Another 5.3 million people have drug coverage under a Medicare Advantage plan, usually an HMO. They had drug coverage in 2005. Now with more taxpayer money being committed to private plans that are already overpaid, according to the nonpartisan Medicare Payment Advisory Commission (MedPAC), they have somewhat better coverage.

About 11.5 million people with Medicare have drug coverage through a stand alone drug plan. Of these, over 1 million were autoenrolled either by Medicare because they were low income, or by their state pharmaceutical assistance program. That leaves roughly 10 million people who voluntarily signed up for the Part D benefit. Does that mean Part D is a well designed program that provides the same health security that people have come to expect from Original Medicare? We think the American people deserve better.

Prescription drug coverage is a crucial component of modern health care coverage. With manufacturers threatening to cut off charitable assistance programs and the Food and Drug Administration ramping up seizures of Canadian medicines, of course people signed up. Part D is just about the only game in town. Congress made sure of that when it decided to give people a bewildering array of plan choices but deny them the one choice they really want—the option of receiving drug coverage directly through Medicare with low prices negotiated by Medicare.

What have people with Medicare experienced under the Part D benefit? Here is a small sampling of the problems our hotline counselors have faced since May 15, when enrollment was closed and much of the press attention shifted away.

- Formulary restrictions imposed by plans like prior authorization, step therapy and quantity limits continue to impair access to vital drugs.
- Complicated and varied appeals procedures make it nearly impossible for consumers to navigate the process alone.
- Consumer confusion continues to plague critical aspects of the program like eligibility for special enrollment periods, calculation of the donut hole and coverage of drugs by Part D versus Part B.
- People continue to learn of limitations in their coverage that were not disclosed by the plans or the agents that enrolled them.
- Problems with coordination of Medicare Part D drug coverage with other benefits like State assistance programs, Medicaid or retiree insurance result in higher than appropriate out-of-pocket costs.
- Many dual eligibles report that Extra Help co-pays are an excessive financial burden.
- Extra Help program is vastly under-enrolled.
- Lack of Medicare coverage of benzodiazepines continues to risk stability of people with certain mental illnesses.
- Financial burden of the donut hole results in people having their treatment interrupted and losing access to critical medicines.

- People who have switched drug plans are not having their accrued drug costs forwarded to their new plan.
- Plans are unaware that individuals who are determined eligible for Extra Help may continue to enroll in drug program.
- Individuals who have switched drug plans are charged premiums for both their old and new plan.
- Mail order pharmacy programs are sending participants the wrong prescriptions.
- People with Extra Help continue to be charged inappropriate co-pays.
- Data mismatches between Social Security, the Centers for Medicare & Medicaid Services (CMS), state Medicaid programs and drug plans are still obstructing access to drug coverage.

The negative publicity that surrounded the implementation of Part D reflected the reality of millions of people with Medicare struggling to afford the medicines they need under a program that was not designed with them in mind. Some, including the Chairman of this Committee, have criticized those who shared the truth about the hundreds of thousands of impoverished Americans whose health and very lives were put at risk by the reckless implementation of Part D earlier this year. Only an honest appraisal of this program can lead to necessary reforms.

Criticism based in reality is not propaganda. Hiding the truth is. Older Americans and people with disabilities can tell the difference. Even the many individuals who experienced no problems with their Part D plan understand: Health insurance—drug coverage—needs to work every time you need it, every time you fall ill. Coverage that works some of the time is not insurance, it is Russian Roulette.

To downplay the very real confusion people with Medicare felt when forced to choose from a dizzying array of plans, each covering different drugs, charging different copayments and subject to change at any time, is about spin, not truth. But these Part D boosters—including some members of this Committee—demand that older Americans be sheltered from news accounts that describe Part D accurately. Disguising the truth is not the path to getting public policy right.

Some of the initial problems with Part D implementation have now abated, but our hotline is fielding a new round of frantic calls as more and more people reach the donut hole, the gap in coverage that is built into Part D. We have yet to find a drug plan that candidly explained this gap in coverage in their advertising. People with Medicare continue to pay premiums but they must also pay full price at the drug store. Estimates suggest thatsome 7 to 10 million people with Medicare are at risk for reaching the coverage gap. Recent research confirms what many knew intuitively: when people reach a limit on their drug coverage and cannot afford to fill their prescriptions, they stop taking their medicines. As a result, they get sick, and Medicare pays the price when they seek emergency care in a hospital. We have no doubt that many people with Medicare will make that fateful choice when they hit the donut hole.

That brings us to our first policy recommendation:

FILL THE DONUT HOLE; MAKE MEDICARE NEGOTIATE LOWER PRICES

I had excellent prescription coverage in a supplemental plan that I received n from the railroad industry. I paid $125 a month for it but my prescriptions only cost $20 for generics and $40 for the brand name drug, and that was for a 4-month supply. The plan stopped covering prescription drugs when Part D started. Sixty days after enrolling, I was in the "donut hole." This is going to cost me more than my previous plan! It is a farce. Congress no longer does any work for the American people who elected them to office. With Part D (for disaster) they turned the job over to the insurance and pharmaceutical companies. I am appalled at my government for shoving this down our throats.

Lawrence
Lady Lake, Florida
Story submitted to Part D monitoring project

We understand that the donut hole resulted from the financial constraints imposed on Congress by the White House when it was debating the Medicare Modernization Act (MMA) in 2003. But the decision to hand the drug benefit over to private insurers rather than have Medicare secure lower prices precluded savings that could have been used to fill the coverage gap. Studies show that if Medicare secured the same prices that the Veterans Administration or other industrialized countries pay, there would be enough money to fill the donut hole. We appreciate

that there is much debate, some of it informed, about this assertion. Circumstantial proof of Medicare's effectiveness as a negotiator is found in the pharmaceutical industry's virulent opposition to allowing Medicare to negotiate drug prices. If private plans were so successful at driving down drug prices, don't you think your former colleague, now lobbying for PhRMA, would be here fighting to require that Medicare, and not the plans, negotiate drug prices? Is this Congress prepared to stand up to the pharmaceutical industry for older Americans and people with disabilities? Existing evidence is not encouraging.

We realize that these are far reaching demands and that many in Congress are invested in the privatized structure they created in Part D. However, there are other steps that Congress can and should take to improve and extend drug coverage to people with Medicare.

ELIMINATE THE ASSET TEST FOR THE LOW INCOME SUBSIDY

Violet, a retired resident of Montgomery County, New York, receives $1006.50 each month from Social Security. Although her monthly income falls below the Extra Help income limit of $1225 per month, she is not eligible because she has $13,000 in assets, $1,500 over the income limit. Because she lives in New York, she can qualify for a Medicare Savings Program (MSP), which will pay her Part B premium and automatically enroll her in the Extra Help program. This is possible because New York has eliminated the asset test for the QI-1 program, the MSP program for people with Medicare earning less than 135 percent of the poverty line. Only five other states have eliminated the asset test for any of their MSP programs.

MRC Client

Since the beginning of the debate of the MMA, there has been widespread, bipartisan agreement that the number one priority of a Medicare drug benefit is to assist the poorest Americans in securing the medication their doctors prescribe. The low income subsidy, popularly called the Extra Help Program, offers the promise of a comprehensive and affordable drug benefit—so long as the patient selects a drug plan that works for her.

One of MRC's key priorities over the past six months has been to enroll as many people in that benefit as humanly possible. With funding from the Starr Foundation and Robin Hood Foundation, among others, we have enlisted hundreds of volunteers to reach out to likely candidates for Extra Help, explain the program to them and whenever possible enroll people online. We are probably as sophisticated as anyone in conducting this work. We advertise a toll free phone number through AARP, chain drug stores, senior centers and elsewhere. We have public service announcements and look to work cooperatively with drug plans, which gain enhanced payments when we sign up their enrollees in Extra Help. We work with pharmaceutical companies that supply us with contact information for people with low incomes who have been disqualified from their patient assistance programs because of Part D: they are good prospects for Extra Help eligibility. Still, the results are dismal: it routinely takes 33 calls by MRC volunteers and staff to identify a likely candidate for the Extra Help Program.

The administration now says that there are 3.2 million people who qualify for the Extra Help program but are not enrolled and have failed to sign up for Part D. That number is surely low. But without quibbling over numbers, we should all agree that leaving 3.2 million impoverished older Americans and people with disabilities without drug coverage, in the context of a trillion dollar benefit program, is not a success story. Congress should take immediate steps to remedy this situation. Pinning our hopes only on renewed outreach efforts will not find and enroll this hard-to-reach population.

The first step is to eliminate the asset test for the Part D program. The asset test disqualifies over half of the low income people with Medicare who apply for Extra Help. It penalizes working class Americans who have diligently saved for their retirement.

The asset test also discourages eligible individuals from applying. It makes the application needlessly complicated, for instance, by requiring individuals to calculate the face value of their life insurance policies. The asset test also creates a barrier to automatically enrolling people based on income data already in the possession of the federal government. When Congress decided to means test the Part B premium for higher income people with Medicare, it found a way to do it automatically, based

on IRS data. Similar efforts should be made to automatically enroll low-income individuals in the Extra Help program.

REQUIRE MEANINGFUL PART D PLAN COMPARISONS

Reasonable public policy would not require people with Medicare to shoot in the dark to pick a drug plan that would work for them. We have worked hard to help people with Medicare select a drug plan that has a good chance of working for them. Secretary Leavitt, according to published reports, made a similar if less successful effort to assist his parents in selecting a drug plan. Las Vegas-style gambling on one's health care is not what we should be purchasing for our parents, our grandparents and ourselves. But that is what Part D provides.

Many callers to MRC's hotlines are among the more sophisticated of consumers. They did what the President and others told them to do. They found help with the internet, they found a plan that said it covered the drugs they now are taking, they found a plan with premiums and deductibles that seemed affordable, and they signed up.

Now they call us in a panic. They never understood that a "covered drug" could come with a $100 per prescription co-payment. They never thought that a "covered drug" would come with trapdoors—requirements that they try other medications first, or that their doctor would have to agree to become a witness in a legal appeal so they could get the "covered drug." Almost no one now hitting the gap in coverage, the infamous donut hole, was told about this by the plans. How many brokers, people earning commissions for each person they enroll, do you think told their customers about the donut hole?

If a majority of the members of Congress continues to support this marketplace experiment, two steps could help: one, Congress should authorize a drug benefit integrated into Medicare to serve as a reliable safe harbor, a genuine choice, for people dissatisfied with the private plans; and two, Congress should force a more finite number of plans into meaningful comparisons that will allow, however imperfectly, some consumers to make a less risky selection.

END MARKETING ABUSES

I am a 47-year old woman who has been disabled for 9 years. I had originally been enrolled in HIRSP, Wisconsin's state insurance plan for high risk members, in which I paid $333 a month to cover my health care costs. This plan covered all of my medications, but the payments were starting to put some strain on my limited resources, making me more receptive when a sales representative from a private insurance Part D plan visited my home.

That's when the trouble started. Though I was concerned about whether or not I could switch back to HIRSP, the salesman convinced me that I would have no problem switching back if I didn't like the plan. I asked him if he was sure, and the salesman told me that a client had recently gone back to HIRSP insurance after four months because he wasn't happy with the plan. I had no reason not to believe him – after all, he seemed very knowledgeable about HIRSP and its policies.

After about two months with this new plan, my health was worsening so I decided to return to HIRSP. However, I was told that because I voluntarily left the insurance plan, I had to wait a year before I could sign up again.

My new plan is costing me much more than I had ever paid with my old insurance, even though it doesn't cover all of my prescriptions, and I have had to skip treatments. A HIRSP representative told me that other people had also been told by this insurance plan that they could switch back when they wanted. I feel that I was duped by this plan, and I worry about others who are also in my situation. Now all I can do is endure the wait until next year.

Sue
West Bend, Wisconsin
Story Submitted to Part D Monitoring Project

MRC's experience with frantic callers to our hotline is leading us to the unhappy conclusion that nearly all marketing of Part D plans is misleading, nearly all of it exploitative of the neediest and frailest older Americans. Worst off are people who

were contacted by telemarketers, a practice sanctioned by CMS. Caller after caller tell us that they did not know much about the plan they had enrolled in, and that they had been told things that were just not true. Other callers tell us that they did not know that they had signed up for an HMO, not a drug plan, until their doctor presented them with a bill and told them he is out of the HMO's "network." Increasingly, as people fall into the gap in coverage, the infamous "donut hole," they are shocked. Why?

The design of this privatized drug program creates a single commercial incentive for the drug plans, the brokers they employ, and the marketing firms they retain. The incentive: market share. Even putting aside purposeful fraud by the unscrupulous, deception is an inevitable by-product of this market created by the MMA and CMS.

Have you reviewed marketing material from the drug plans? Have you heard sales pitches at free breakfast meetings? At senior centers? A plan with a low deductible or a low premium will highlight that feature. People will be sold low deductible plans without understanding the other side: restricted formulary, rigid medication utilization tools, and excessive costs per prescription. How many members of Congress have seen plan marketing materials—TV ads, brochures radio spots—talk about the gap in coverage? Even CMS is part of the problem. Late last year CMS spent untold public dollars running an insert about Part D in Parade Magazine. CMS, supposedly explaining the standard drug benefit, neglected to even mention the donut hole. Shareholders are protected by the Securities Exchange Commission and securities laws. Aren't older Americans entitled to similar protections from the predatory practices of the insurance industry? Deception comes in many forms: omitting material information from drug plan advertising is one that is epidemic in Part D.

Telemarketing of drug plans must be banned, and all marketing materials must be limited to accurate and comprehensive comparisons of standardized plans.

IMPROVE ACCESS TO MENTAL HEALTH DRUGS

Karen has Medicare and Medicaid and was autoenrolled in the AARP plan offered by United Healthcare. In January, she attempted to fill prescriptions for three antidepressants, Mirtazapine, Wellbutrin and Cymbalta, but United Healthcare would not pay for the prescribed doses. United Healthcare set a quantity limit for each drug at 30 pills per month.

Karen has Severe Refractory Depression and has been prescribed numerous combinations of various drugs over the past eight years. Lower doses of all three drugs had been tried and failed to provide relief. According to both her treating physician and a consulting psychiatrist, this is the only combination that gives her any relief.

Despite this evidence of medical necessity, United Healthcare twice denied coverage of these medicines at the prescribed dosages. Maximus, the independent review entity contracted by CMS, also rejected Karen's appeal. The case is now before an administrative law judge.

MRC Client

Clients continue to flock to MRC seeking help with barriers drug plans are putting in the way of access to antidepressants and antipsychotics, drugs commonly needed by people with mental illnesses. As you know, CMS required plans to cover "all or substantially all" of these medicines, along with drugs in four other critical therapeutic classes. But that requirement is being undermined by other restrictions imposed by plans—prior authorization, step therapy and quantity limits. Quantity limits, in particular, are billed as "safety edits," but drug plans (seeking, of course, to maximize profits) generally impose them only on the most expensive drugs. Cost, not safety, is motivating the plans.

One important, and relatively inexpensive, class of drugs—benzodiazepines—is excluded by law from Part D coverage. This exclusion threatens the stability of the drug regimens of many people with mental illness. Most state Medicaid programs continue to provide coverage but many people with low incomes do not qualify for Medicaid, and states are under financial pressure to cut back coverage. In Florida, people who qualify for Medicaid through spend down are finding it difficult to maintain access to these medicines.

Congress should end the exclusion of benzodiazepines from the Part D benefit. It should ensure adequate coverage of mental health drugs and should enjoin plans

from doing an end run around formulary requirements with utilization management dodges.

STANDARDIZE, STREAMLINE PART D EXCEPTIONS AND APPEALS

Parts A and B of Medicare have worked well because they are based on the concept that individuals will have access to care deemed medically necessary by their treating physician. In theory, drugs under Part D are supposed to follow a comparable concept: while Part D consists of a patchwork of plans with various options and limitations on prescriptions, the MMA also includes exceptions and appeals provisions intended to allow individuals to access medically necessary drugs.

We now know from our first hand experience that the current system fails to deliver on this bedrock concept—access to medications that are medically necessary. Over the last several months MRC has helped hundreds of men and women take on the Part D appeals system. Most of our appellate clients had been denied access to medically necessary medications, and almost all were stymied by the Part D appeals process. Here are ways to improve this flawed, consumer hostile system:

- standardize the appeals process and forms;
- streamline the appeals process; and
- provide resources for independent consumer organizations to provide representation to people denied medically necessary medicine.

The Part D appeals process is impossible for the average consumer to navigate. Following near universal criticism, the recent move to standardize the coverage determination request form is a welcome, but very small start. Use of these forms by plans is voluntary, and they are only the first step in a multi-step appeals process. Steps must be taken to standardize the rest of the appeals process. There should be one form and one set of rules for obtaining an exception. That form and those rules should be posted on the CMS website and mailed to all people with Medicare. Obtaining life-saving medications should not be akin to navigating a mine-field.

I have been denied coverage for Byetta, a medication I have been on for my diabetes for nearly a year. When I was first denied, I was told by my Part D plan, Wellcare, that my doctor only needed to fill out a form and the Byetta would be added to the allowed list, which it has not. I have been denied coverage for this medication. I have also had to get prior authorization for my asthma meds, Singulair and Spriva. It took over a month to get the authorization, during which time I became ill. I am constantly charged copays on syringes, insulin and albuterol, which I did not have to pay before Part D. I get charged copays for generic meds, which are supposed to have a $0 copay. I have called the insurance company and have been told that my many prescriptions cost too much, and I will have to pay copays on everything. I have tried to work with the pharmacy to get all of my prescriptions. They now look at me like I am a problem when I go to pick up a prescription.

Andrea
East Wareham, Massachusetts
Submitted to Part D Monitoring Project

A standardized appeals process must also be a streamlined one. Individuals should receive a formal denial before they leave their pharmacy, complete with straightforward instructions on how to appeal that denial. After an initial appeal to a Part D plan, individuals would then appeal directly to the Independent Review Entity.

This would cut out an unnecessary and generally futile step. Currently, after being denied a claim at the pharmacy, people with Medicare must ask the plan twice to cover their drug before receiving an independent review. Drugs subject to prior authorization require three requests for coverage at the plan level before an independent review is allowed. Each of these preliminary steps causes delays in violation of mandatory timelines and at considerable risk to the well being of the patient.

Further, for the current process to be meaningful, people with Medicare require assistance in prosecuting appeals. The current system assumes a helpful and willing physician. Do members of this Committee know many doctors who are routinely willing to take on arduous, uncompensated paperwork for the sake of their patients? And who is to help patients pursue appeals?

As noted, MRC is listed on plan denial forms as a go-to patient advocate for people denied coverage of medicines prescribed by their doctors.

How much does CMS contribute to this representation?

Nothing.

How much do the drug plans contribute?

Less.

If Congress wants people with Medicare to have access to medically necessary drugs, it must standardize and streamline the Part D appeals process, and provide assistance to individuals with bona fide appeals of a plan's denial of medically necessary medications.

DELAY ENROLLMENT PENALTY AND END LOCK-IN

Now that the May 15th enrollment deadline has passed, many people find themselves locked in to their prescription drug plan or locked out of drug coverage all together until the next open enrollment period. Starting July 1, people will be locked in to their Medicare Advantage plan.

The prospect of a late enrollment penalty, which accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises, created needless anxiety among people with Medicare already frustrated by a confusing choice of plans. As a result, many people enrolled in plans without knowing what the coverage restrictions are, or that they will only be able to use doctors and hospitals that are in-network. Many have been deceived by plan marketing agents on these very issues.

MRC has spent the last 15 years helping people disenroll from their Medicare HMO so that they could continue to receive care from their treating physician. Others need to disenroll when they discover that the plan provides no help with cost sharing for chemotherapy or other serious illnesses. Among drug plan enrollees, plans' failure to cover their medicines is the primary reason people seek to disenroll. The administration should lift lock-in under its broad authority to create special enrollment periods. If it fails to act, Congress should step in.

The prospect of a late enrollment penalty creates needless anxiety among people with Medicare already frustrated by a confusing choice of plans. The late enrollment penalty accrues during the months people with Medicare are locked out of drug coverage after May 15 and will rise each year as the average drug plan premium rises. With all the problems and confusion associated with the roll-out of the Part D benefit, it is inevitable that some people with Medicare will miss the enrollment deadline. Congress should step in and waive the late penalty for 2006.

ENACT A MEDICARE DRUG BENEFIT

These reforms would be helpful, because we believe in the principle that anything that helps a single person is a worthy reform. But, even with these reforms the drug benefit will continue to waste billions of dollars that could better be used to deliver a reliable and comprehensive drug benefit to people with Medicare *through the Medicare program.*

Americans need affordable prescription drug coverage that meets our changing health care needs, a program that cover the drugs we need today—and the drugs we will need tomorrow. Medicare provides a cost effective and largely affordable safety net, reliably allowing older and disabled Americans the peace of mind and the security of knowing that medically necessary and reasonable health care services will be covered. There is a human cost to abandoning that Medicare design for the coverage of prescription drugs.

To provide a benefit as good as we can afford with finite dollars, we think the lessons of Part D—objectively evaluated—teach that Congress should enact:

- A drug benefit administered directly by Medicare, without the waste and restrictions that come with private health insurers as commercial, profit seeking middleman;
- Negotiated drug prices that keep costs down; and
- One comprehensible, reliable and secure drug benefit that adapts to the needs of the American people now and in the future.

Health security, not a health care lottery, is what people with Medicare require. People may in good faith still believe, even after the evidence of 2006, that the new cottage industry of for-profit middlemen hawking incomprehensible drug benefit packages is the way to go. We do not think so. But we are content to allow those plans to continue, so long as these middlemen face a real market. Let the for-profit insurers compete with a Medicare drug benefit, one that fights for lower prices, and keeps administrative costs low and profiteering non-existent.

Honest supporters of a market approach cannot fear competition, not even from Medicare. There is nothing to fear but a better deal for people with Medicare and a fairer deal for the American taxpayer.

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